Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MASSHEALTH
TRANSMITTAL LETTER DEN-74
February 2006

TO: Dental Providers Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: Revised Dental Regulations and Service Codes

This letter transmits revisions to the MassHealth dental regulations effective March 1, 2006. The revised regulations

- define and implement "caseload capacity," which allows dental providers to limit the number of MassHealth members they serve as described in detail in this letter;
- eliminate the DPH license requirement for state owned and operated dental clinics;
- provide coverage of occlusal appliances for certain members;
- clarify that hygienists may provide periodontal scaling and root planning; and
- eliminate the prior-authorization requirement for oral screening for members undergoing radiation treatment, chemotherapy, or organ transplantation.

A revised Subchapter 6 and Appendix E of the *Dental Manual* are also attached and reflect changes previously described in Transmittal Letter DEN-71, issued in November 2005, regarding:

- reimbursement for nonemergency, medically necessary treatment provided during an emergency care visit;
- minimum number of radiographs required for a full-mouth series;
- time period for reimbursement for oral prophylaxis;
- reimbursement for sealants;
- elimination of the restrictions on the number of teeth upon which root-canal therapy may be performed during a period of treatment;
- elimination of the prior-authorization (PA) requirement for mouth guards, diagnostic photographs, and surgical removal of soft tissue and partial bony impaction;
- decreased time limits and PA requirements for periodic oral evaluations;
- reimbursement for topical fluoride treatments;
- reimbursement for four or more surface composite restorations on a single anterior or posterior tooth; and
- limit on the number of certain resin crowns for primary teeth to four per date of service.

Caseload Capacity

Caseload capacity is effective for dates of service on or after March 1, 2006. Caseload capacity is defined as a "MassHealth dental provider's good-faith determination of the number of MassHealth members to whom the provider is able to provide dental services."

A provider's dental practice will either be considered **"Open, Accepting"** or **"Closed, Not Accepting"** as described below.

- **Open, Accepting** indicates that the provider is accepting new MassHealth members *unless and until* the provider notifies MassHealth Customer Service that its dental practice is Closed, Not Accepting. In other words, "Open, Accepting" is the default status for providers.
- **Closed, Not Accepting** indicates that the provider's dental practice is not accepting any new MassHealth members.

Caseload Capacity Guidelines

In order to provide MassHealth members with the most accurate status of each MassHealth dental provider practice, MassHealth asks that providers follow the guidelines below.

- Continue to accept new patients until you have determined that you are unable to accept any more new patients. (Note: You may continue to accept new family members of existing patients even if your practice is considered "Closed, Not Accepting.")
- Promptly notify MassHealth Customer Service using the fax number or e-mail address below when your individual, group or facility practice has reached the number of MassHealth members you are able to serve stating your practice is "Closed, Not Accepting."
- Group practices, community health centers, hospital licensed health centers, and acute and chronic hospital outpatient departments must establish a single caseload capacity for the entire group or facility. That is, if one or more dentists within a provider group is accepting MassHealth members who are new to the practice, the status would be "Open, Accepting."
- The caseload capacity status of your dental practice will be available to MassHealth members.

Caseload Capacity Changes

Dental providers who want to change the status of their dental practice should notify MassHealth Customer Service either via fax at 617-988-8974, or via e-mail at providersupport@mahealth.net.

New Service Codes

For dates of service on or after March 1, 2006, MassHealth will cover the following service codes:

D0160 Detail and extensive oral evaluation – problem focused, by report (to be billed **only** for oral screening for members undergoing radiation treatment, chemotherapy, or organ transplant)
D5720 Rebase maxillary partial denture (cast partial denture only) **(under 21 only)** (P.A.)
D5721 Rebase mandibular partial denture (cast partial denture only) **(under 21 only)** (P.A.)
D5760 Reline maxillary partial denture (laboratory) (cast partial denture only) **(under 21, PW and S.C. only)** (P.A.)
D5761 Reline mandibular partial denture (laboratory) (cast partial denture only) **(under 21, PW and S.C. only)** (P.A.)
D9940 Occlusal guard **(under 21 only)** (P.A.)

PA for Medically Necessary Noncovered or Unlisted Services for Members Under Age 21

MassHealth covers medically necessary dental services, subject to the Early and Periodic Screening, Diagnosis and Treatment provisions set forth at 130 CMR 450.144(A), which provides for prior authorization for medically necessary unlisted, limited or non-covered services.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

MassHealth has updated **Appendix G** (Utilization Management Program) to reflect current practices and information.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Dental Manual

Pages iv, iv-a, vi, vii, 4-1 through 4-44, 6-1 through 6-8, E-1 through E-30, G-1, and G-2

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Dental Manual

Pages iv, iv-a, 4-1, 4-2, 4-37, 4-38, and 6-1 through 6-10 — transmitted by Transmittal Letter DEN-73

Pages vi, 4-15, and 4-16 — transmitted by Transmittal Letter DEN-68

Page vii — transmitted by Transmittal Letter DEN-48

Pages 4-3 through 4-6, 4-17, 4-18, 4-21, 4-22, 4-29, 4-30, 4-33, 4-34, 4-39, and 4-40 — transmitted by Transmittal Letter DEN-62

Pages 4-7 and 4-8 — transmitted by Transmittal Letter DEN-64

Pages 4-9 through 4-14, G-1, and G-2 — transmitted by Transmittal Letter DEN-72

Pages 4-19, 4-20, 4-23 through 4-28, 4-31, 4-32, 4-35, 4-36, and 4-41 through 4-46 — transmitted by Transmittal Letter DEN-59

Pages E-1 through E-6 — transmitted by Transmittal Letter DEN-71

Pages E-7 through E-30 — transmitted by Transmittal Letter DEN-66

4. PROGRAM REGULATIONS

4. PROGRAM REGULATIONS (cont.)

6. SERVICE CODES AND DESCRIPTIONS

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, billing instructions, and general information. MassHealth regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. MassHealth regulations are assigned Title 130 of the Code. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For dental services, those matters are covered in 130 CMR Chapter 420.000, reproduced as Subchapter 4 in the *Dental Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen-and-ink" revisions), and by substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth’s effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

420.401: Introduction

(A) 130 CMR 420.000 contains regulations governing dental services under MassHealth. All dental providers participating in MassHealth must comply with the regulations of the MassHealth agency governing MassHealth, including but not limited to MassHealth regulations at 130 CMR 420.000 and 450.000.

(B) In general, and as further described below, coverage of dental services varies for
(1) members under age 21;
(2) members aged 21 and older with special circumstances that meet the criteria in 130 CMR 420.410(D);
(3) members aged 21 and older who are either pregnant or a mother with a child under the age of three years; and
(4) all other members aged 21 and older.

(C) Coverage for members under age 21 includes services essential for the prevention and control of dental diseases and the maintenance of oral health. Coverage for members aged 21 and older with special circumstances that meet the criteria in 130 CMR 420.410(D) is similar, but not identical, to coverage for members under age 21. Coverage for all other members aged 21 and older includes emergency care, exodontic services, oral surgery, and some X-ray services.

(D) The service descriptions and limitations applicable to each group are set forth in the regulations that follow. Where noted, certain service descriptions are the same for all members, regardless of age or circumstances.

420.402: Definitions

The following terms used in 130 CMR 420.000 have the meanings given in 130 CMR 420.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 420.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 420.000 and in 130 CMR 450.000.

Caseload Capacity – for purposes of this regulation, caseload capacity means a MassHealth dental provider's good-faith determination of the number of MassHealth members to whom the provider is able to provide dental services.

Controlled Substance – a drug listed in Schedule II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Drug – a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Interchangeable Drug Product – a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A"-rated) by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

Legend Drug – any drug for which a prescription is required by applicable federal or state law or regulation.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 420.418(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 420.000.

Multiple-Source Drug – a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Nonlegend Drug – any drug for which no prescription is required by federal or state law.

Pharmacy Online Processing System (POPS) – the online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Unit-Dose Distribution System – a means of packaging and/or distributing drugs in unit doses, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken. Such unit doses may or may not be in unit-dose packaging.

420.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for dental services provided to MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105 specifically states for each MassHealth coverage type, which services are covered and the members eligible to receive those services.
(2) Recipients of Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

420.404: Provider Eligibility: Participating Providers

The MassHealth agency makes payment for services described in 130 CMR 420.000 only to providers of dental services who are participating in MassHealth on the date of service. The participating provider is responsible for the quality of all services for which payment is claimed, the accuracy of such claims, and compliance with all regulations applicable to dental services under MassHealth. In order to claim payment, the participating provider must be the dentist who actually performed the service.

(A) A dentist who is a member of a group practice can direct payment to the group practice under the provisions of MassHealth regulations governing billing intermediaries in 130 CMR 450.000. The dentist furnishing the services must be enrolled as an individual provider, and must be identified on claims for his or her services.

(B) A dental school may claim payment for services provided in its dental clinic.

(C) A dental clinic may claim payment for services provided in its dental clinic.

(D) A community health center, hospital-licensed health center, managed care organization, or hospital outpatient department may claim payment for services provided in its dental clinic.

(E) A dental laboratory may claim payment for prosthetic material delivered to a dentist if the material was not otherwise provided or paid for by the dentist.

420.405: Provider Eligibility

(A) In-State Providers. The following requirements apply when the dental provider is located in Massachusetts.

(1) Practitioner. A dentist engaged in private practice is eligible to participate in MassHealth if licensed to practice by the Massachusetts Board of Registration in Dentistry. Private practices may include, but are not restricted to, solo, partnership, or group practices.

(2) Managed Care Organization. A managed care organization with a dental clinic is eligible to participate in MassHealth as a provider of dental services.

(3) Community Health Center. A licensed community health center is eligible to participate in MassHealth as a provider of dental services.

(4) Dental School. A teaching clinic of a dental school accredited by the American Dental Association is eligible to participate in MassHealth as a provider of dental services.

(5) Dental Laboratory. When a dentist's salary from a hospital, state institution, or nursing facility includes compensation for professional services furnished to members in that facility, a dental laboratory is eligible to be a provider and to be paid for the prosthetic materials supplied to a dentist where such materials are not otherwise provided or paid for by the dentist.

(6) Hospital Outpatient Department and Hospital-Licensed Health Center. Dental services provided to members in a hospital outpatient department's dental clinic or a hospital-licensed health center are paid for in accordance with the hospital's signed provider agreement with the Executive Office of Health and Human Services (EOHHS).

(7) Dental Clinic. A dental clinic must be licensed by the Massachusetts Department of Public Health (DPH) to be eligible to participate in MassHealth. A DPH license is not required for a state owned and operated dental clinic. A dental clinic that limits its services to education and diagnostic screening is not eligible to participate.

(8) Specialist in Orthodontics. A dentist who is a specialist in orthodontics must have completed a minimum of two years' training in an accredited postgraduate program leading to board eligibility or board certification as a Diplomate of the American Board of Orthodontists.

(9) Specialist in Oral Surgery. A dentist who is a specialist in oral surgery must have completed a minimum of three years' training in an accredited oral and maxillofacial surgical program as prescribed by the American Board of Oral and Maxillofacial Surgery. An oral surgeon who is also a licensed medical doctor must bill in accordance with the regulations in 130 CMR 420.000 governing the dental program.

(B) Out-of-State Providers. A dental provider located outside of Massachusetts is eligible to be a participating provider in MassHealth and to be paid for dental services provided to MassHealth members only if the provider is licensed or certified by the state in which the provider practices, the provider meets the specific provider eligibility requirements listed in 130 CMR 420.404, and the provider meets the conditions set forth in 130 CMR 450.109.

420.406: Caseload Capacity

(A) A MassHealth dental provider must promptly notify the MassHealth agency when its individual, group, or facility practice has reached the number of MassHealth members to whom the provider is able to provide dental services and is closed, as well as when its practice is accepting new MassHealth members and its caseload capacity is open.

(B) Group practices, community health centers, and acute hospital outpatient departments must establish a single caseload capacity for the entire group or facility.

420.407: Maximum Allowable Fees

(A) Introduction. The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for all dental services purchased by government agencies. DHCFP publishes a comprehensive listing of dental services and rates. The MassHealth agency pays for a limited number of the services listed by DHCFP. Refer to Subchapter 6 of the *Dental Manual* for the MassHealth agency's list of covered services. Payment is always subject to the conditions, exclusions, and limitations set forth in the regulations in 130 CMR 420.000. Payment for a service will be the lower of the following:

(1) the provider's usual charge to the general public for the same or a similar service; or
(2) the maximum allowable fee listed in the applicable DHCFP fee schedule.

(B) Services for Members Under the Age of 21 and for Members Aged 21 and Older. The scope of reimbursable dental services is more extensive for members under the age of 21, and for members aged 21 and older who have special circumstances that meet the criteria for prior authorization set forth in 130 CMR 420.410(D) than for other members aged 21 and older. If the service is reimbursable only for members under the age of 21, or for a more restricted age group, that is noted in the service description in 130 CMR 420.000.

420.408: Noncovered Services

MassHealth does not cover the following dental services, subject to the Early and Periodic Screening, Diagnosis and Treatment provisions set forth at 130 CMR 450.144(A), which provide for prior authorization for medically necessary unlisted, limited, or noncovered services:

(A) cosmetic services;

(B) overdentures and their attachments;

(C) implants of any type or description;

(D) counseling or member-education sessions;

(E) unilateral partials;

(F) laminate veneers;

(G) tooth splinting for periodontal purposes;

(H) medical or dental treatment of temporomandibular joint (TMJ) disease;

(I) habit-breaking appliances;

(J) occlusal guards for members aged 21 and older;

(K) orthotic splints, including mandibular orthopedic repositioning appliances (MORAs);

(L) ridge augmentations;

(M) grafts of any nature;

(N) root canals filled by silver point technique, or paste only;

(O) oral-hygiene devices and appliances, dentifrices, and mouth rinses;

(P) procedures and techniques that are considered unproven or experimental, or that are not approved by the American Dental Association and its related certifying specialty boards as currently accepted dental practice;

(Q) other specialized techniques and associated procedures; and

(R) all other procedures and services not listed in the *Dental Manual*.

420.409: Noncovered Circumstances

(A) Conditions. The MassHealth agency does not pay providers for dental services under any of the following conditions:

(1) services provided in a state institution by a state-employed dentist or a dental consultant;

(2) services furnished by a provider whose salary includes compensation for professional services;

(3) if, under comparable circumstances, the provider does not customarily bill private members who do not have health insurance; or

(4) if the member is not an eligible MassHealth member on the date of service. The provider must verify the member's eligibility for MassHealth on the date of service even if the provider has obtained prior authorization for the service.

(B) Substitutions.

(1) If a member desires a noncovered substitute for, or a modification of, a covered item, the member must pay for the entire cost of the service. The MassHealth agency does not pay for any portion of the cost of a noncovered service. In all such instances, before performing noncovered services, the provider must inform the member both of the availability of covered services and of the member's obligation to pay for noncovered services.

(2) It is unlawful (M.G.L. c. 6A, § 35) for a provider to accept any payment from a member for a service or item for which payment is available under MassHealth. If a member claims to have been misinformed about the availability of covered services, it will be the responsibility of the provider to prove that the member was offered a covered service, refused it, and chose instead to accept and pay for a noncovered service.

420.410: Prior Authorization

(A) Introduction.

(1) In order for certain services (listed in 130 CMR 420.410(C) and (D)) to be payable, the MassHealth agency requires that the provider obtain prior authorization. The MassHealth agency pays for these services, which are designated in Subchapter 6 and Appendix E of the *Dental Manual* with the abbreviation "P.A.," only when the provider has obtained prior authorization from the MassHealth agency. Prior authorization requests are reviewed for medical necessity, including prognosis of treatment. The provider must not begin to furnish the service, except as provided under 130 CMR 420.410(A)(2), until the provider has requested and received written prior authorization from the MassHealth agency. A treatment plan must be included with the prior authorization request for endodontics and crowns. A request for prior authorization should include all services proposed for treatment.

(2) The MassHealth agency may grant prior authorization after a procedure has begun if, in the judgment of the MassHealth agency, this treatment is medically necessary. When such a prior-authorization request is made, the provider must provide a written justification that the treatment will:

(a) alleviate suffering of the member;

(b) address a dental emergency; or

(c) involve an extenuating circumstance that must be detailed by the dentist.

(3) Requests for prior authorization must be submitted according to the instructions in Subchapter 5 of the *Dental Manual*.

(4) The MassHealth agency does not consider prior-authorization requests for noncovered services for members aged 21 and older (see 130 CMR 420.408 and service limitations described throughout 130 CMR 420.000).
(5) Pursuant to 130 CMR 450.144(A), the MassHealth agency will consider prior-authorization requests for non-covered services for members under age 21.

(B) Other Requirements for Payment.
(1) Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health-insurance payment.
(2) The MassHealth agency will not pay for a prior-authorized service when the member's MassHealth eligibility is terminated on or before the date of service or a date adjudicated by the MassHealth agency.
(3) When the member's MassHealth eligibility is terminated before delivery of a special-order good, such as a denture, the provider may claim payment in accordance with the provisions of 130 CMR 450.231(B). Refer to 130 CMR 450.231(B) for special procedures in documenting member eligibility for special-order goods.

(C) Services Requiring Prior Authorization.
(1) Services requiring prior authorization include, but are not limited to, the following:
(a) periodontal scaling and root planing;
(b) gingivectomy or gingivoplasty;
(c) occlusal guard;
(d) interceptive orthodontic treatment visits;
(e) orthodontic treatment;
(f) diagnostic casts;
(g) crowns, posts, cores, and fixed bridgework;
(h) endodontics (root canals and apicoectomies);
(i) prosthodontics (full, partial, and immediate dentures);
(j) rebase of complete upper or lower denture;
(k) reline of complete upper or lower denture;
(l) removal of complete bony impacted tooth;
(m) surgical exposure of impacted tooth or unerupted tooth to aid eruption (for orthodontic purposes);
(n) vestibuloplasties (ridge extensions);
(o) excision of hyperplastic tissue, per arch;
(p) use of a hospital (inpatient or outpatient) or a freestanding ambulatory surgery center;
(q) certain surgical services performed in a hospital (for example, orthognathic surgery);
(r) +additional fee for management of a physically or developmentally disabled member in the office;
(s) maxillofacial prosthetics; and
(t) any other service designated "P.A." in Subchapter 6 or Appendix E of the *Dental Manual*.

(2) The prescription of certain drugs requires prior authorization, as specified in 130 CMR 420.418.

(D) Prior Authorization for Diagnostic, Preventive, Restorative, Prosthodontic, and Endodontic Services for Members Aged 21 and Older. The MassHealth agency pays for diagnostic, preventive, restorative, prosthodontic, and endodontic services (described in 130 CMR 420.432 through 130 CMR 420.439) for members aged 21 and older only when the provider has obtained prior authorization from the MassHealth agency that the member meets the special circumstances criteria set forth in 130 CMR 420.410(D)(1).

(1) To demonstrate special circumstances, the member must have

(a) a severe, chronic disability that

(i) is attributable to a mental or physical impairment or combination of mental or physical impairments;

(ii) is likely to continue indefinitely; and

(iii) results in the member's inability to maintain oral hygiene; or

(b) a clinical condition (such as human immunodeficiency virus or cancer) that has advanced to a stage where an infection resulting from oral disease would likely be life-threatening.

(2) The provider's prior-authorization request must contain a clear, written statement signed by the member's physician or primary care clinician (on the clinician's letterhead) describing the member's disability or clinical condition, including but not limited to, the member's specific diagnosis and expected prognosis, and

(a) whether, and specifically why, the member's disability results in the member's inability to maintain oral hygiene; or

(b) whether the member's clinical condition has advanced to a stage where an infection resulting from oral disease would likely be life-threatening, including reference to specific supporting diagnostic evidence.

(3) For purposes of 130 CMR 420.410(D)(1)(a) and (2)(a), "inability to maintain oral hygiene" means that

(a) the member is unable to

(i) independently or with assistance (provided that such assistance actually is available), brush and floss his or her teeth and perform other routine acts of personal oral hygiene; or

(ii) report oral pain; or

(b) the nature of the member's disability is such that routine acts of personal oral hygiene are insufficient to effectively maintain such hygiene.

420.411: Pretreatment Review

Where the MassHealth agency identifies an unusual pattern of practice of a given provider, the MassHealth agency, at its discretion and pursuant to written notice, may require the provider to submit any proposed treatments identified by the MassHealth agency, including those not otherwise subject to prior authorization, for the MassHealth agency's review and approval before treatment.

420.412: Individual Consideration

(A) Certain services are designated "I.C." (indicating individual consideration) in Subchapter 6 and Appendix E of the *Dental Manual*. This means that a fee could not be established for these services. Service codes for unlisted or unspecified procedures are also designated as "I.C." The MassHealth agency determines appropriate payment for individual-consideration services from the provider's detailed report of services furnished. The report must include a narrative summary or operative report, and laboratory, radiographs, and pathology reports. The MassHealth agency does not pay claims for "I.C." services without a complete report. If the documentation is illegible or incomplete, the MassHealth agency will deny the claim.

(B) Determination of the appropriate payment for an individual-consideration service is in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies; and
(5) any extenuating circumstances or complications.

420.413: Separate Procedures

Certain procedures are designated "S.P." in the service descriptions in Subchapter 6 and Appendix E of the *Dental Manual*. "S.P." is an abbreviation for separate procedure. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but that commands a separate fee when performed as a separate procedure not immediately related to other services. (For example, the MassHealth agency does not pay for a frenulectomy when it is performed as part of a vestibuloplasty, and full-study models are not reimbursable separately when performed as part of orthodontic treatment or diagnosis; however, the MassHealth agency does pay for full-study models separately when they are requested by the MassHealth agency.) The administration of analgesia and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

420.414: Recordkeeping Requirements

Federal and state regulations require that all MassHealth providers maintain complete written records of patients who are members. All records, including radiographs, must be kept for a minimum of four years after the date of service. Records for members who are residents of long-term-care facilities must be retained by the dentist as part of the member's dental record and by the nursing facility as part of the member's record at the facility. The fees for all dental services listed in 130 CMR 420.000 include payment for preparation of the member's dental record. Services for which payment is claimed must be substantiated by clear evidence of the nature, extent, and necessity of care furnished to the member. Evidence must include examination results, diagnostic charting, description of treatment, radiographs, and findings of other diagnostic tests. For all claims under review, the member's medical and dental records determine the appropriateness of services provided to members. The written dental record corresponding to the services claimed must include, but is not limited to, the following:

(A) the member's name, date of birth, and sex;

(B) the member's identification number;

(C) the date of each service;

(D) the name and title of the individual servicing provider furnishing each service, if the dental provider claiming payment is not a solo practitioner;

(E) pertinent findings on examination and in medical history;

(F) a description of any medications administered or prescribed and the dosage given or prescribed;

(G) a description of any anesthetic agent administered, the dosage given, and the anesthesia flowsheet;

(H) a complete identification of treatment, including, when applicable, the arch, quadrant, tooth number, and tooth surface;

(I) dated and mounted radiographs, if applicable; and

(J) copies of all approved prior-authorization requests.

420.415: Report Requirements

(A) General Report. A general written report that includes a diagnosis and a description of the service performed must accompany the claim for payment when the service description in Subchapter 6 or Appendix E of the *Dental Manual* stipulates "with report only," when the service is designated "I.C.," or when a service code for an unlisted procedure is used. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of services performed. The report can be on the claim form or on a separate piece of paper with the provider's letterhead. Supporting documentation, including pathology, admission, and operative reports, must be attached.

(B) Operative Report. For surgical procedures designated "I.C." and for any service that is an unlisted or unspecified procedure, an operative report must accompany the provider's claim. An operative report must contain the name of the surgical procedure, the name and date of birth of the member, the date of the service, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and of any assistant, and the technical procedures performed.

420.416: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. Legend drugs, nonlegend drugs, and those medical supplies listed at 130 CMR 420.417(C) are covered only if the pharmacy has in its possession a prescription that meets all requirements for a legal prescription under all applicable federal and state laws and regulations. Each prescription, regardless of drug schedule, must contain the prescriber's unique DEA number. For Schedule VI drugs, if the practitioner has no DEA registration number, the practitioner must provide the state registration number on the prescription.

(B) Emergencies. When the pharmacy determines that an emergency exists, the MassHealth agency will pay a pharmacy for at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations. Emergency dispensing to a MassHealth member who is enrolled in the Controlled Substance Management Program (CSMP) must comply with 130 CMR 406.442(C)(2).

(C) Refills.

(1) The MassHealth agency does not pay for prescription refills that exceed the specific number authorized by the prescriber.

(2) The MassHealth agency pays for a maximum of 11 monthly refills, except in circumstances described in 130 CMR 420.416(C)(3).

(3) The MassHealth agency pays for more than 11 refills within a 12-month period if such refills are for less than a 30-day supply and have been prescribed and dispensed in accordance with 130 CMR 420.416(D).

(4) The MassHealth agency does not pay for any refill dispensed after one year from the date of the original prescription.

(5) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

(6) The MassHealth agency does not pay for any refill without an explicit request from a member or caregiver for each filling event. The possession by the provider of a prescription with remaining refills does not in itself constitute a request to refill the prescription.

(D) Quantities.

(1) Days' Supply Limitations. The MassHealth agency requires that all drugs be prescribed and dispensed in at least a 30-day supply, but no more than a 90-day supply, unless the drug is available only in a larger minimum package size, except as specified in 130 CMR 420.416(D)(2).

(2) Exceptions to Days' Supply Limitations. The MassHealth agency allows exceptions to the limitations described in 130 CMR 420.416(D)(1) for the following products:

(a) drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;

(b) drugs that, in the prescriber's professional judgment, are not clinically appropriate for the member in a 30-day supply;

(c) drugs that are new to the member, and are being prescribed for a limited trial amount, sufficient to determine if there is an allergic or adverse reaction or lack of effectiveness. The initial trial amount and the member's reaction or lack of effectiveness must be documented in the member's medical record;

(d) drugs packed in such a way that the smallest quantity that may be dispensed is larger than a 90-day supply (for example, inhalers, ampules, vials, eye drops, and other sealed containers not intended by the manufacturer to be opened by any person other than the end user of the product);

(e) drugs in topical dosage forms that do not allow the pharmacist to accurately predict the rate of the product's usage (for example, lotions or ointments); and

(f) products generally dispensed in the original manufacturer's packaging (for example, fluoride preparations, prenatal vitamins, and over-the-counter drugs).

(E) Prescription-Splitting. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the prescriber. For example, a prescription written for a single 30-day supply may not be split into three 10-day supplies. The MassHealth agency considers prescription-splitting to be fraudulent. (See 130 CMR 450.238(B)(6).)

420.417: Pharmacy Services: Covered Drugs and Medical Supplies

(A) Drugs. The MassHealth Drug List specifies the drugs that are payable under MassHealth. In addition, the MassHealth agency pays only for legend drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8.

(B) Medical Supplies. The MassHealth agency pays only for the following medical supplies:

(1) blood and urine testing reagent strips used for the management of diabetes;

(2) disposable insulin syringe and needle units;

(3) insulin cartridge delivery devices and needles or other devices for injection of medication (for example, Epipens);

(4) lancets;

(5) drug delivery systems for use with metered dose inhalers (for example, aerochambers); and

(6) alcohol swabs.

420.418: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent, unless:

(1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 420.419); and

(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The MassHealth agency does not pay for the following types of drugs or drug therapy.

(1) Cosmetic. The MassHealth agency does not pay for legend or nonlegend preparations for cosmetic purposes or for hair growth.

(2) Cough and Cold. The MassHealth agency does not pay for legend or nonlegend drugs used solely for the symptomatic relief of coughs and colds, including but not limited to, those that contain an antitussive or expectorant as a major ingredient unless dispensed to an institutionalized member.

(3) Fertility. The MassHealth agency does not pay for any drug used to promote male or female fertility.

(4) Obesity Management. The MassHealth agency does not pay for any drug used for the treatment of obesity.

(5) Smoking Cessation. The MassHealth agency does not pay for any drug used for smoking cessation.

(6) Less-Than-Effective Drugs. The MassHealth agency does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.

(7) Experimental and Investigational Drugs. The MassHealth agency does not pay for any drug that is experimental, medically unproven, or investigational in nature.

(C) Service Limitations.

(1) The MassHealth agency covers drugs that are not explicitly excluded under 130 CMR 420.418(B). The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 420.000. The MassHealth Drug List can be viewed online at www.mass.gov/druglist, and copies may be obtained upon request. The MassHealth agency will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List accordingly. (See 130 CMR 450.303.)

(2) The MassHealth agency does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs;

(c) drugs used for the treatment of male or female sexual dysfunction;

(d) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The MassHealth agency, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993; and

(e) topical acne products for members aged 21 or older. The MassHealth agency pays for topical acne products for members under age 21, and all other topical acne products for members of all ages who have cases of acne Grade II or higher, without prior authorization.

(3) The MassHealth agency does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) The MassHealth agency does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the MassHealth agency determines to be consistent with current medical evidence.

(5) The MassHealth agency does not pay for drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307.

(D) Insurance Coverage.

(1) Managed Care Organizations. The MassHealth agency does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth Standard MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107 and 450.117.

(2) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 420.418(C)(2)(a), (c), (d), and (e). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, see 130 CMR 450.101 et seq.

420.419: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the MassHealth agency for drugs identified by the MassHealth agency in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 420.417(A) and 420.418(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to the MassHealth agency for prior authorization for an otherwise noncovered drug.

(B) All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Dental Manual*. If the MassHealth agency approves the request, it will notify both the pharmacy and the member.

(C) The MassHealth agency will authorize at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See U.S.C. 1396r-8(d)(5).) The MassHealth agency acts on requests for prior authorization for a prescribed drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements of other health insurers.

(E) The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 420.416 through 420.419. The MassHealth agency will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List.

420.420: Pharmacy Services: Member Copayments

Under certain conditions, the MassHealth agency requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether legend or nonlegend) covered by MassHealth. The copayment requirements are detailed in 130 CMR 450.130.

420.421: Service Descriptions and Limitations: Introduction — Members Under Age 21

Service descriptions and limitations that are specific to members under age 21 are set forth in 130 CMR 420.422 through 420.429. Services that apply to all members, including members under age 21, are set forth in 130 CMR 420.452 through 420.456. In addition, services provided to members under age 21 must comply with all applicable requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services set forth in 130 CMR 450.140 through 450.149.

420.422: Service Descriptions and Limitations: Diagnostic Services — Members Under Age 21

The following service descriptions and limitations apply to preventive services provided to members under age 21.

(A) Comprehensive Oral Evaluation. A comprehensive oral evaluation by a dentist of a new member is reimbursable. A comprehensive oral evaluation is more thorough than a periodic oral evaluation, and is reimbursable only once per member for a dentist, dental group, or dental clinic. A comprehensive oral evaluation includes a written review of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, the diagnosis, and the preparation of treatment plans and reporting forms.

(B) Periodic Oral Evaluation. A periodic oral evaluation is reimbursable, twice per twelve-month period. A periodic oral evaluation includes an update of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, diagnosis, and the preparation of treatment plans and reporting forms. This service is not reimbursable on the same date of service as an emergency treatment visit and is not reimbursable if the visit results in a referral to a specialist.

(C) Emergency Dental Care. An emergency care visit is one that is intended to eliminate or alleviate acute pain or infection or both. Services that may be provided as part of an emergency care visit are those minimally required to address the immediate emergency and include, but are not limited to, diagnosis, draining of an abscess, prescribing pain medication or antibiotics, or treatment of the emergency. The provider must maintain in the member's dental records a diagnostic report of the treatment provided and must document the emergent nature of the care provided. Radiographs subject to limitations set forth in 130 CMR 420.423 and dental management of a physically or developmentally disabled member in the office (see 130 CMR 420.457) are reimbursable with a visit for emergency dental care. Other covered nonemergency, medically necessary treatment provided during the same visit is reimbursable.

420.423: Service Descriptions and Limitations: Radiographs — Members Under Age 21

The following service descriptions and limitations apply to radiograph services provided to members under age 21.

(A) Introduction. Radiographs must be taken as an integral part of diagnosis and treatment planning. The intent of limitations placed on radiographs is to confine radiation exposure of members to the minimum necessary to achieve satisfactory diagnosis. The provider must document efforts to obtain any previous radiographs before prescribing more. Radiographs must be of good diagnostic quality and, when submitted to the MassHealth agency, must be properly and securely mounted, dated, labeled for right and left views, and fully identified with the names of the dental provider and the member. When radiographs submitted to the MassHealth agency are not of good diagnostic quality, the provider may not claim payment for any retake radiographs requested by the MassHealth agency. Prior-authorization requests that are submitted with radiographs that are not of good diagnostic quality will be deferred, pending submission of radiographs that are of good diagnostic quality, or denied. Radiographs are considered to be of good diagnostic quality when they meet the following criteria:

(1) standard illumination permits differentiation between the various structures of the tooth, the periodontal ligament spacings, the supporting bone, and the normal anatomic landmarks;
(2) all crowns and roots, including apices, are fully depicted together with interproximal alveolar crests, contact areas, and surrounding bone regions; and
(3) images of all teeth and other structures are shown in proper relative size and contour with contiguous images, where anatomically possible.

(B) Intraoral Radiographs.

(1) (a) Full-Mouth Radiographs. Full-mouth radiographs are reimbursable only for members 13 through 20 years of age and only once every three calendar years without prior authorization. Prior authorization is required for more frequent radiographs. Full-mouth radiographs must consist of either a minimum of 10 periapical films and two posterior bitewing films, or two-to-four bitewing films and/or two periapical films taken with a panoramic film. Radiographs must be of good diagnostic quality as defined in 130 CMR 420.423(A). However, panoramic films cannot be substituted for radiographs required for prior authorization. When the provider's total fee for individual periapical films (with or without bitewings) exceeds the MassHealth agency's reimbursement for a full-mouth series, the provider may claim reimbursement only in an amount not to exceed the MassHealth agency's reimbursement for a full-mouth series.

(2) Bitewing Survey. The MassHealth agency pays for up to four bitewing films as separate procedures no more than twice per calendar year. Bitewing films may not be billed separately when taken as part of a full-mouth series. Prior authorization is required for more frequent radiographs.

(3) Periapical Films. Periapical films may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the MassHealth agency. A maximum of four periapical films is allowed per visit. Prior authorization is required for more frequent radiographs.

(C) Panoramic Films. Panoramic films are not reimbursable for crowns, endodontics, periodontics, and interproximal caries.

(1) Surgical Conditions. Panoramic films are reimbursable in conjunction with surgical conditions. Surgical conditions include, but are not limited to:

(a) impactions;
(b) teeth requiring extractions in more than one quadrant;
(c) large cysts or tumors that are not fully visualized by intraoral films or clinical examination;
(d) salivary-gland disease;
(e) maxillary-sinus disease;
(f) facial trauma; and
(g) trismus where an intraoral film placement is impossible.

(2) Nonsurgical Conditions The MassHealth agency pays for only one panoramic film per member for nonsurgical conditions for members between the ages of six and 11 years to monitor the growth and development of permanent dentition.

(D) Diagnostic Photographic Prints.

(1) The MassHealth agency accepts only photographic prints, not slides, to support prior-authorization requests for orthodontic treatment. In addition, the MassHealth agency may request models. Seven photographic prints are required for prior authorization both for initial fabrication and insertion of the orthodontic appliance and for first-year orthodontic treatment visits as well as for prior-authorization requests for progress approval. If original photographic prints are not available, photographic prints of the models in the positions required in 130 CMR 420.423(D)(1)(a) through (c) are acceptable. The photographic prints must be mounted in clear plastic holders to allow viewing, and include the first molars. In addition, the photographic prints must include

(a) two photographic prints of the member's face (full face and side view);
(b) three photographic prints of teeth in occlusion (front and two side views); and
(c) two photographic prints of the occlusal mirror view of maxillary and mandibular teeth.

(2) Payment for photographic prints is included in the fees for orthodontic services. The MassHealth agency does not pay for photographic prints as a separate procedure (see 130 CMR 420.413) when prior authorization is granted for orthodontic diagnosis or treatment. An orthodontic specialist must send diagnostic photographic prints to the MassHealth agency as part of a prior-authorization request for orthodontic treatment. Members who satisfy conditions for comprehensive orthodontic treatment may have treatment authorized. If such treatment is approved, the MassHealth agency will grant prior authorization to the provider to bill the treatment. The fee for the orthodontic treatment includes reimbursement for orthodontic diagnosis and records, models, photographic prints, and radiographs. However, if the treatment is denied based on the diagnostic photographic prints, the MassHealth agency will grant prior authorization for the provider to obtain reimbursement for the photographic prints only.

(3) The MassHealth agency may request diagnostic photographic prints for other prior-authorization services outlined in 130 CMR 420.000.

420.424: Service Descriptions and Limitations: Preventive Services — Members Under Age 21

The following service descriptions and limitations apply to preventive services provided to members under age 21.

(A) Prophylaxis. Prophylaxis is reimbursable twice per 12-month period without prior authorization. The MassHealth agency may authorize this service at greater frequency if, in the MassHealth agency's opinion, the provider's description of the condition substantiates the need for additional prophylaxis (for example, if a mentally retarded or developmentally disabled individual with gingival disease has a limited ability for self-care). The prophylaxis must include a scaling of natural teeth, removal of acquired stains, and polishing of the teeth. As part of the prophylaxis, the practitioner must review with the member oral-hygiene methods including toothbrush instruction and flossing methods.

(B) Fluoride.

(1) Topical Fluoride Treatment. Topical fluoride treatment is reimbursable. Topical fluoride treatment consists of continuous topical application of an approved fluoride agent such as gels, foams, and varnishes, for a period shown to be effective for the agent. Treatment that incorporates fluoride with the polishing compound is considered to be part of prophylaxis and is not reimbursable as a separate procedure.

(2) Fluoride Supplements. The MassHealth agency pays for fluoride supplements through the pharmacy program.

(C) Periodontal Scaling and Root Planing. Periodontal scaling and root planing is a periodontal procedure that is reimbursable, when indicated, once per quadrant every three years. The provider must obtain prior authorization to perform this service. The provider must include complete periodontal charting, sufficient periapical films for diagnosis, and a statement concerning the member's periodontal condition with the prior-authorization request. The MassHealth agency does not pay for prophylaxis provided on the same day as periodontal scaling and root planing or on the same day as a gingivectomy or a gingivoplasty. The MassHealth agency pays only for periodontal scaling and root planing of two quadrants on the same date of service in an office setting.

(D) Gingivectomies and Gingivoplasties. Gingivectomies and gingivoplasties are reimbursable once per quadrant every three years. The provider must obtain prior authorization to perform this service. The provider must include complete periodontal charting, sufficient periapical films for diagnosis, appropriate documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition with the prior-authorization request. The MassHealth agency does not pay for a gingivectomy performed on the same day as a prophylaxis or periodontal scaling and root planing. The MassHealth agency pays only for the gingivectomy or gingivoplasty of two quadrants on the same date of service in an office setting.

(E) Sealants. Sealants are reimbursable for primary or permanent first and second noncarious molars, and first and second noncarious bicuspids that have deep pits and fissures. Sealants are also reimbursable for noncarious third molars that have deep pits and fissures. This service includes proper preparation of the enamel surface, etching, and placement and finishing of the sealant. This service is reimbursable only once every three years per tooth. The provider must replace sealants lost or damaged during the three-year period.

(F) Occlusal Guard. Only custom fitted laboratory processed occlusal guards designed to minimize the effects of bruxism (grinding) and other occlusal factors are reimbursable. All follow-up care is included in the reimbursement. Prior authorization is required.

(G) Mouth Guard. Only custom-fitted mouth guards are reimbursable. The MassHealth agency pays for a mouth guard only if the member is engaged in an organized contact sport and only when the organization has no provision for the purchase of mouth guards for its participants. Mouth guards are not covered as antibruxim devices.

420.425: Service Descriptions and Limitations: Restorative Services — Members Under Age 21

The following service descriptions and limitations apply to restorative services provided to members under age 21. The MassHealth agency considers all of the following to be components of a completed restoration and includes them in the fee for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia, and polishing. The MassHealth agency does not pay for restorations replaced within one year of the date of the completion of the original restoration.

(A) Amalgam Restorations.

(1) Cavity preparation must have an outline adequate for retention and extended to conform to the principles of prevention of recurrent caries.

(2) Payment will not be made for restorations attempted on primary teeth when early exfoliation (more than two-thirds of the root structure resorbed) is expected.

(3) Only one restoration per tooth surface per year is reimbursable. Occlusal surface restorations, including all occlusal pits and fissures, are reimbursable as a one-surface restoration whether or not the transverse ridge on an upper molar is left intact.

(4) No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the maximum allowable fee for a four-or-more-surface amalgam restoration.

(B) Composite Resin Restorations.

(1) Composite restorations are reimbursable for all surfaces of anterior and posterior teeth.

(2) For anterior teeth, the MassHealth agency pays no more than the maximum allowable amount for four-or-more-surface composite restoration regardless of what other services are performed on the same tooth during the composite restoration treatment period and regardless of the combination of surfaces.

(3) For a single posterior tooth, the MassHealth agency pays no more than the maximum allowable amount for a four-or-more-surface composite restoration regardless of what other services are performed on the same tooth during the composite restoration treatment period.

(4) Restoration of a fractured permanent anterior tooth with composite material and bonding or its equivalent is reimbursable when used instead of a full-crown restoration. The fee for this service includes payment for the use of any pins. Prior authorization is required to perform this service on other than permanent anterior teeth.

(5) The fee for all composite resins includes payment for etching and bonding.

(6) Full-coverage composite crowns are reimbursable for anterior primary teeth.
(7) Preventive resin restorations are reimbursable only on occlusal surfaces and only as a single-surface posterior composite. Preventive resin restorations include instrumentation of the occlusal surfaces of grooves.

(C) Reinforcing Pins. Reinforcing pins are reimbursable only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. For teeth where four or more surfaces are restored, either commercial amalgam bonding systems or pins are reimbursable.

(D) Crowns, Posts, and Cores.
(1) Crowns, posts, and cores require prior authorization from the MassHealth agency. For crowns, posts, and cores, the MassHealth agency grants prior-authorization requests only when both the prognosis of the tooth and remaining dentition is excellent, and then only when the MassHealth agency determines that conventional restorations cannot be placed due to extensive loss of tooth structure, or when an amalgam or a composite restoration with pins will not withstand the forces of mastication. Acrylic jacket crowns (laboratory processed only) are reimbursable.
(2) The prior-authorization request must include a treatment plan and be justified by a sufficient number of peripical films of good diagnostic quality, dated and suitably mounted, to judge the general dental health. At a minimum, the request must be accompanied by a periapical film of the tooth and two posterior bitewing films. The MassHealth agency reserves the right to request current full-mouth radiographs or photographs, or both.
(3) Members are eligible for crowns, posts, and cores on permanent incisors, cuspids, bicuspids, and first molars only.
(4) If root-canal therapy is intended or has been performed previously, the MassHealth agency grants prior-authorization requests for crowns, posts, and cores only if the loss of coronal tissue precludes a functional occlusion of the tooth. A radiograph of the completed root-canal therapy on the tooth must accompany the request. Payment for progress radiographs on root canals is included in the fee for root-canal therapy.
(5) Payment is not authorized for crowns provided solely for cosmetic reasons.
(6) When a provider treatment plan includes both root-canal therapy and a post and core with crown, the provider may submit either a single prior-authorization request for both procedures, or a separate prior-authorization request for each procedure to the MassHealth agency. In either case, each prior-authorization request must contain sufficient information to support the medical need for the procedures requested. A radiograph of successful root-canal therapy must be maintained in the member's record.
(7) The MassHealth agency pays for stainless-steel crowns for primary and permanent posterior teeth or prefabricated resin crowns for primary and permanent anterior teeth. Stainless-steel or prefabricated resin crowns are limited to instances where the prognosis is favorable and must not be placed on primary teeth that are mobile or show advanced resorption of roots. The MassHealth agency pays for no more than four stainless-steel or prefabricated resin crowns per date of service. Prior authorization is not required.
(8) Payment for crown repair does not require prior authorization by the MassHealth agency except where the repair involves laboratory fees or extensive professional time from the dental provider. In these circumstances, providers must submit to the MassHealth agency requests for prior authorization and individual consideration. The prior-authorization request must include radiographs and documentation of estimated laboratory costs.

(E) Fixed Bridgework.

(1) Fixed bridgework requires prior authorization. The MassHealth agency grants prior-authorization requests only for fixed bridgework for anterior teeth and only for members aged 16 through 20, with fully matured teeth. The member's oral health must be excellent and the prognosis for the life of the bridge and remaining dentition must be excellent.

(2) The provider must submit radiographs of good diagnostic quality, dated and suitably mounted, with the request for prior authorization.

(3) Payment for fixed bridgework repair does not require prior authorization by the MassHealth agency except where the repair requires laboratory fees or extensive professional time from the dental provider. In these circumstances, providers must submit requests for prior authorization and individual consideration for fixed bridgework repair to the MassHealth agency. The prior-authorization request must include radiographs and documentation of estimated laboratory costs.

420.426: Service Descriptions and Limitations: Endodontic Services — Members Under Age 21

The following service descriptions and limitations apply to endodontic services provided to members under age 21. The maximum allowable fee for endodontic services includes payment for all radiographs performed during the same treatment session.

(A) Pulpotomy.

(1) A pulpotomy is reimbursable and consists of the complete removal of the coronal portion of the pulp to maintain the vitality of the tooth. It is limited to instances when the prognosis is favorable, and must not be applied to primary teeth that are mobile or that show advanced resorption of roots.

(2) For primary teeth, treatment is limited to cuspids and posterior teeth for members aged 10 years or younger, and primary incisor teeth for members aged five years or younger. Exceptions to these age limits require prior authorization.

(3) When provided in the same period of treatment, a pulpotomy is not reimbursable in conjunction with root-canal therapy.

(B) Root-Canal Therapy.

(1) Root canal therapy requires prior authorization. This service is limited to the permanent dentition and then only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition. Root-canal therapy on second or third molars is not reimbursable. Requests for prior authorization must include a total diagnosis and treatment plan supported by radiographs of remaining teeth. These radiographs must be of good diagnostic quality, dated and suitably mounted. The MassHealth agency authorizes root-canal therapy only when the prior-authorization requirements for a crown (130 CMR 420.425(D)) are met. If the member will subsequently need a crown, the provider may submit either a single prior-authorization request for the combined post, core, crown, and root-canal treatment, or a separate prior-authorization request for each treatment procedure.

(2) The MassHealth agency does not authorize payment for root-canal therapy if

(a) the prognosis of the involved tooth is poor; or

(b) the involved tooth could be extracted and incorporated into an existing or allowable denture.

(3) Payment for root-canal therapy is limited to permanent incisors, cuspids, bicuspids, and first molars.
(4) All root canals must be properly prepared, shaped, and condensed to the apex.
(5) The maximum allowable fee for root-canal therapy includes payment for all preoperative and postoperative treatment; diagnostic (for example, vitality) tests; and pretreatment, treatment, and post-treatment radiographs.
(6) A radiograph of the completed root canal must be maintained in the member's record.

(C) Apicoectomy.
(1) An apicoectomy as a separate procedure requires prior authorization, and follows root-canal therapy when the canal is not to be reinstrumented. The request for prior authorization must include a treatment plan and substantiate valid evidence of the need for the service. The fee for the procedure includes payment for the retrograde filling and removal of pathological periapical tissue.
(2) The fee for an apicoectomy with root canal filling includes payment for the filling of the canal or canals and removing the pathological periapical tissue and any retrograde filling in the same period of treatment. This procedure requires prior authorization.
(3) The MassHealth agency applies the criteria at 130 CMR 420.426(B) regarding root-canal therapy when evaluating prior-authorization requests for apicoectomies.

420.427: Service Descriptions and Limitations: Prosthodontic Services — Members Under Age 21

The following service descriptions and limitations apply to prosthodontic services provided to members under age 21.

(A) Dentures: General Conditions.
(1) All of the following dentures are reimbursable with prior authorization only:
(a) full dentures;
(b) immediate dentures:
(c) partial upper and partial lower dentures with conventional clasps and rests; and
(d) partial upper and partial lower dentures with bar, conventional clasps, and rests.
(2) The MassHealth agency pays for relining of cast partial dentures. The MassHealth agency does not pay for the relining of resin-base partial dentures.
(3) The MassHealth agency does not pay for overdentures, precision attachments, temporary dentures, cusil-type dentures, or other dentures of specialized designs or techniques.
(4) The provider must submit a complete treatment plan and prosthetic history with the request for prior authorization.
(5) As part of the denture fabrication technique, the member must approve the teeth and set-up in wax before the dentures are processed.
(6) The member's identification must be on each denture.
(7) All dentures must be initially inserted and subsequently examined and adjusted by the dentist at reasonable intervals consistent with practice in the community or at the member's request.
(8) The MassHealth agency pays for the replacement of dentures only under certain circumstances (see 130 CMR 420.427(F)). The member is responsible for denture care and maintenance. The member, or those responsible for the member's custodial care, must take all possible steps to prevent the loss of the member's dentures. The provider must inform the member of the MassHealth agency's policy on replacing dentures and the member's responsibility for denture care.

(B) Denture Treatment Plan and Prosthetic History.

(1) A prosthetic history must include, but is not limited to, the following information, as applicable:

(a) identification of the teeth to be extracted and, for partial dentures, the teeth to be clasped and replaced;

(b) the length of time the member has been without natural teeth;

(c) the age and current status of previous or present dentures;

(d) whether the MassHealth agency paid for previous or present dentures;

(e) the length of time the member has been without dentures; and

(f) photographs showing the condition of existing dentures and residual ridges, if requested.

(2) If the member still has natural teeth, the provider must submit with the treatment plan a current series of periapical and bitewing films of good diagnostic quality, dated and suitably mounted, of all remaining teeth. If the member has no remaining natural teeth, radiographs are not required (see 130 CMR 420.423(B)(4)). The fee for full dentures includes payment for all necessary adjustments, including relines, within six months after insertion of the denture. The fee for a partial denture includes payment for all necessary clasps and rests, regardless of the number.

(C) Full Dentures.

(1) Only permanent dentures are reimbursable. When the provider requests initial full dentures following multiple extractions, generally a period of two months must elapse between the time of the extractions and the time the impressions are taken.

(2) Immediate dentures are reimbursable only when the following conditions are met.

(a) These dentures will be the permanent full dentures.

(b) There are no more than six anterior teeth and no more than one posterior tooth to be extracted at the time of insertion of the denture.

(c) Impressions for the immediate dentures were taken after a suitable period of healing in the region where the posterior teeth were extracted.

(d) There is a favorable prognosis for adaptation to the immediate dentures.

(3) Preformed dentures with mounted teeth (that is, teeth that have been set in acrylic before the initial impressions) are not reimbursable.

(4) Fabrication of a denture must be specific to the individual member, consisting of the individual positioning of teeth, wax-up of the entire denture body, and conventional laboratory processing.

(D) Partial Dentures.

(1) The MassHealth agency considers prior-authorization requests for permanent partial-denture construction only if there are fewer than eight sound posterior teeth in good occlusion. The remaining dentition must be sound and have a good prognosis. Existing or planned crowns, bridges, and partial or full dentures, when present, are counted as occluding teeth.

(2) The MassHealth agency may also consider a request for a permanent partial denture when the member is missing anterior teeth.

(3) The provider must submit to the MassHealth agency an outline of the design of the permanent denture, including the identity of the teeth to be replaced and the teeth to be clasped, and current periapical and bitewing films of the remaining teeth, dated and suitably mounted.
(4) Design of the prosthesis must be as simple as possible, consistent with the basic principles of prosthodontics.
(5) The provider must certify that all carious teeth are functionally restored and that the supporting structures are in good health.
(6) Partial upper and lower dentures with bar are reimbursable.

(E) Dentures for Members in Long-Term-Care Facilities.
(1) Dental services for members in long-term-care facilities must emphasize retention of the existing dentition consistent with the health and comfort of the member. Most persons in long-term-care facilities adapt better to repairs and other adjustments to existing dentures rather than to extractions or new dentures.
(2) Dentures for members in long-term-care facilities require prior authorization. The provider must submit the following information with a prior-authorization request: a detailed statement of the member's level of medical care; a detailed medical history and diagnosis; medical evaluation of assigned diet and assessment of functional nutritional status; a description of the member's capacity to communicate and to cooperate; and a statement that the member has expressed a desire for the dentures. This documentation must be signed by the member's guardian, or the facility's director of nursing, and a copy must be included in the member's record at the long-term-care facility.
(3) The MassHealth agency does not authorize payment for dentures unless the MassHealth agency has determined that the member is capable of adjusting to a prosthesis. The provider must not prescribe dentures without the express consent of the member. Neither the absence of teeth nor cosmetic benefit, alone or in combination, is considered to be a sufficient reason for dentures. In many cases the member is better served with the fabrication of only an upper denture.
(4) The MassHealth agency reserves the right to request diagnostic photographic prints. (See 130 CMR 420.427(B)(1)(f).)

(F) Replacement of Dentures. The MassHealth agency pays for the necessary replacement of dentures, subject to prior authorization. The MassHealth agency does not authorize payment for the replacement of dentures if the member's denture history reveals any of the following conditions:
(1) repair or reline will make the existing denture usable;
(2) any of the dentures made previously have been unsatisfactory due to physiological causes that cannot be remedied;
(3) a clinical evaluation suggests that the member will not adjust satisfactorily to the new denture;
(4) no medical or surgical condition in the member necessitates a change in the denture or a requirement for a new denture;
(5) the existing denture is less than seven years old and no other condition in this list applies;
(6) the denture has been relined within the previous two years;

(7) the loss of the denture was not due to extraordinary circumstances such as a fire in the home. The request for prior authorization must include documentation, such as a fire report, police report of theft, or photographic prints of broken dentures; or
(8) the member has been edentulous for more than two years, has been functioning satisfactorily without dentures and no significant improvement in the member's health can reasonably be anticipated if the member were to use dentures.

(G) Antidiscrimination Policy. No provider may discriminate against a MassHealth member. If a hospital or nursing facility has a denture-replacement policy in place for other types of insurance carriers and private paying members, the same policy must apply to MassHealth members in the hospital or nursing facility.

(H) Full-Denture Relines and Rebases. Payment for all full-denture relines and rebases requires prior authorization. The MassHealth agency pays only for full denture relines that are laboratory processed or light cured. "Cold-cure" relines are not reimbursable. The fee for dentures includes payment for any relines or rebases necessary within six months of the dispensing date of the denture. Subsequent relines or rebases are reimbursable with prior authorization once every two years. More frequent relines or rebases require prior authorization and evidence that clinical conditions exist that warrant more frequent relines or rebases (for example, a member with head and neck cancer). The request for prior authorization must include a description of the condition of the denture and must fully justify the reason that an additional reline or rebase is necessary. If a reline or rebase is performed, the MassHealth agency will not authorize an additional denture for three years for the same member. The MassHealth agency may require photographic prints of the mouth and existing dentures to support a request for prior authorization.

(I) Maxillary and Mandibular Partial Dentures – Cast Metal Framework Relines and Rebases. Payment for all cast partial denture relines and rebases requires prior authorization. The MassHealth agency pays only for partial denture relines that are laboratory processed or light cured. "Cold-cure" relines are not reimbursable. The fee for partial dentures includes payment for any relines or rebases necessary within six months of the dispensing date of the partial denture. Subsequent relines or rebases are reimbursable with prior authorization once every two years. More frequent relines or rebases require prior authorization and evidence that clinical conditions exist that warrant more frequent relines or rebases (for example, a member with head and neck cancer). The request for prior authorization must include a description of the condition of the partial denture and must fully justify the reason that an additional reline or rebase is necessary. If a reline or rebase is performed, the MassHealth agency will not authorize an additional partial denture for three years for the same member. The MassHealth agency may require photographic prints of the mouth and existing dentures to support a request for prior authorization. Relines and rebases are not covered for resin-based partial dentures.

(J) Resin-Based Partial Dentures. Relines and rebases are not covered for resin-based partial dentures.

420.428: Service Descriptions and Limitations: Orthodontic Services — Members Under Age 21

The following service descriptions and limitations apply to orthodontic services provided to members under age 21.

(A) General Requirements. Orthodontic treatment is reimbursable only once per member per lifetime. The provider must begin treatment before a member is 18 years and six months of age so that it is completed before the member reaches age 21. However, the MassHealth agency will pay for the continuation of full orthodontic treatment as long as the member remains eligible for MassHealth, provided that initial treatment started before the member reached age 18 years and six months. This payment limitation also applies to any pre- or post-orthognathic surgical case.

(B) Prior Authorization.

(1) The provider must obtain prior authorization for all orthodontic treatment except for orthodontic consultation and retention following orthodontic treatment from the MassHealth agency. The reimbursement for orthodontic retention includes the fabrication and delivery of retainers and follow-up visits. The maximum number of reimbursable retention visits (post-treatment stabilization) is five.

(2) In order to initiate a prior-authorization request for orthodontic treatment, a provider must submit diagnostic photographic prints for the MassHealth agency's review (see 130 CMR 420.423(D)). If the photographic prints do not substantiate the need for treatment, as determined by application of the clinical standard described in Appendix D of the *Dental Manual*, the MassHealth agency either denies the treatment or requests that the provider submit orthodontic models, photographic prints, and radiographs. These are reimbursed only when they are requested by the MassHealth agency.

(a) If the prior-authorization request for treatment is approved based on the documentation submitted, the provider will be given prior authorization to bill the service described as "initial fabrication and insertion of orthodontic appliance," which is reimbursable once per member per lifetime and includes reimbursement for records, photographic prints, models, and radiographs. Initial fabrication and insertion of orthodontic appliances includes conventional, complete, and comprehensive state-of-the-art orthodontic treatment.

(b) If the prior-authorization request for treatment is denied based on the documentation submitted, the provider will be granted prior authorization to bill the service described as "orthodontic diagnosis and records, models, photographic prints, and radiographs."

(c) If the prior-authorization request for treatment is approved based on the documentation submitted, and the member moves or refuses further treatment, the orthodontist may bill the service described as "orthodontic diagnosis and records, models, photographic prints, and radiographs," billable once per member per lifetime. The records, or copies of them, may be requested by another orthodontist. The MassHealth agency may reimburse the second orthodontist for records at its discretion only when initial records are invalid or outdated. The orthodontist must retain pre- and post-treatment photographic prints in the member's dental record for review.

(C) Orthodontic Consultation. The MassHealth agency reimburses accredited orthodontists for an orthodontic consultation for the purpose of determining the necessity for orthodontic treatment and assessing the appropriate time to commence treatment. This service is limited to members who are younger than 18 years and six months of age. An orthodontic consultation is reimbursable as a separate procedure (see 130 CMR 420.413) and only once per six-month period. An orthodontic consultation is not reimbursable as a separate procedure when used in conjunction with ongoing or planned (within six months) orthodontic treatment. The fee for this service does not include models, or photographic prints, and prior authorization is not required. The MassHealth agency does not pay for more than one orthodontic consultation or examination on the same date of service.

(D) Orthodontic Radiographs. Radiographs as a separate procedure for orthodontic diagnostic purposes require prior authorization and are reimbursable only for members under the age of 18 years and six months. Cephalometric films are to be used in conjunction with orthodontic diagnosis. Payment for radiographs in conjunction with orthodontic diagnosis is included in the fees for orthodontic services. Payment is not made for additional radiographs from the same or another provider when required for orthodontic diagnosis. The provider must use the service code for orthodontic radiographs when billing for a full-mouth series or for panoramic films including bitewings.

(E) Interceptive Orthodontic-Treatment Visits. The goal of preventive or interceptive orthodontics is to prevent or minimize a developing malocclusion with primary or mixed dentition. Use of this treatment should preclude or minimize the need for any additional orthodontic treatment. The provider must obtain prior authorization for the number of adjustment visits in conjunction with an interceptive appliance.

(F) Space Maintainers. Space maintainers and replacement space maintainers are reimbursable. Although the initial space maintainer does not require a prior authorization, replacement space maintainers do require prior authorization. Space maintainers are indicated when there is premature loss of teeth that may lead to loss of arch integrity. For primary cuspids, space maintainers prevent midline deviation, loss of arch length and circumference. Premature loss of primary molars also indicates the use of space maintainers to prevent the migration of adjacent teeth. The loss of primary incisors usually does not require the use of a space maintainer. An initial diagnostically acceptable radiograph must be maintained in the member's record, demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. The provider must maintain good diagnostic-quality radiographs in the member's record. For replacement space maintainers, the provider must include an explanation of the reason for requesting the replacement space maintainer with the request for prior authorization. Treatment (adjustment) visits are not reimbursable for passive space maintainers.

(G) Comprehensive Orthodontic Treatment. Comprehensive orthodontic treatment is reimbursable only once per member per lifetime and only when the member has a severe and handicapping malocclusion. The MassHealth agency determines whether a malocclusion is severe and handicapping based on the clinical standards described in Appendix D of the *Dental Manual*. The permanent dentition must be reasonably complete (usually by age 11).

(1) Reimbursement covers a maximum period of two and one-half years of orthodontic treatment visits. The provider must request prior authorization for initial fabrication and insertion of the orthodontic appliance. Reimbursement for the initial fabrication and insertion of the orthodontic appliance includes payment for records and all appliances associated with treatment, fixed and removable (for example, rapid palatal expansion (RPE) or Head Gear). Retention (removal of appliances, construction and placement of retainers) is a separate, billable service, which also includes all retention visits. In addition, the provider must request prior authorization separately for each year of treatment (first, second, and, if necessary, first half of the third year).

(2) When requesting prior authorization for the initial fabrication and insertion of the orthodontic appliance and the first year of orthodontic treatment, the provider must submit the following (see the instructions in Subchapter 5 of the *Dental Manual* for obtaining prior authorization forms):

(a) a signed statement on the provider's letterhead that all restorative services have been completed, with diagnostic radiographs demonstrating completion of restorative services (see 130 CMR 420.423(A) and (B)), and an evaluation of the anticipated level of member cooperation and hygiene;

(b) seven diagnostic photographic prints, mounted in clear plastic holders, two of which must include frontal and profile facial views and five intraoral views including anterior, left and right lateral views taken at 90 degrees, and occlusal views taken with a mirror;

(c) a completed PAR Index recording form, which provides results of applying the clinical standards described in Appendix D of the *Dental Manual*;

(d) a completed orthodontics prior-authorization form; and

(e) a completed prior-authorization form.

(3) When requesting prior authorization for orthodontic treatment visits subsequent to the first year, for each subsequent year of treatment (the second, and, if necessary, the first half of the third year), the provider must submit the original photographic prints, intraoral progress photographic prints, an updated progress statement for each year of treatment that all restorative services have been completed with diagnostic radiographs (see 130 CMR 420.423(A) and (B)), an updated evaluation of anticipated cooperation and hygiene, and a copy of the initially submitted orthodontics prior-authorization form with Part IV completed with progress to date.

(4) Upon the completion of orthodontic treatment, the provider must take photographic prints and maintain them in the member's medical record, subject to review by the MassHealth agency at its discretion.

(H) Orthodontic Treatment Visits. The provider must request prior authorization for each of the first, second, and, if necessary, first half of the third years of orthodontic treatment visits. The MassHealth agency pays for ongoing orthodontic treatment visits on a quarterly basis only for members in active orthodontic treatment. The MassHealth agency considers a member to be in active orthodontic treatment if the member's dental record indicates that orthodontic treatment was provided in the previous 90 days or if the provider includes a justification in the member's dental record for maintaining the member's active status (for example, extended illness). Broken appointments alone do not justify a lapse in service beyond 90 days. If a member becomes inactive for any period of time, prior authorization is not required to resume orthodontic treatment visits and subsequent billing unless the prior-authorization time limit has expired. Orthodontists should see members every four-to-six weeks. However, the MassHealth agency recognizes that illness or other extenuating circumstances may cause MassHealth members to occasionally miss appointments. Therefore, the MassHealth agency requires that MassHealth members receive treatment visits in at least eight out of 12 months in an authorized year of treatment before billing for the next treatment year. The MassHealth agency requires that three treatment units of one quarter each be billed before requesting prior authorization for the second and third year of treatment. The number and dates of visits must be documented in the member's orthodontic record.

(I) Replacement Retainers. The MassHealth agency pays for a replacement retainer only during the two-year retention period following orthodontic treatment. The provider must obtain prior authorization and include the date of onset of retention with the request for prior authorization.

(J) Retention. The MassHealth agency pays separately for orthodontic retention (removal of appliances, construction and placement of retainer(s)). Retention includes the fabrication and delivery of the retainers(s) and follow-up visits. The maximum number of reimbursable retention visits (post-treatment stabilization) is five. Prior authorization is not required.

(K) Early Appliance Removal. A prior-authorization request for early appliance removal must include documentation of parent or guardian authorization and an explanation from the orthodontist.

(L) Patient Noncooperation. If the provider determines that continued orthodontic treatment is not indicated because of lack of member cooperation, the provider may request individual consideration for appliance removal. At this time, the provider may also request approval for the placement of retainers.

(M) Additional Consultation. The MassHealth agency may request additional consultation for any orthodontic procedure requiring prior authorization.

(N) Orthodontic Models and Study Models. Orthodontic models and study models are reimbursable as separate procedures only when requested by the MassHealth agency as part of a prior-authorization request for treatment procedures and only when the study models are of good diagnostic quality, properly articulated, well trimmed, and poured in white plaster. Payment for orthodontic models is otherwise included in the fees for orthodontic services. Payment will not be made for an orthodontic model as a separate procedure when prior authorization is granted for orthodontic diagnosis or treatment.

420.429: Service Descriptions and Limitations: Exodontic Services — Members Under Age 21

The following service descriptions and limitations apply to exodontic services provided to members under age 21.

(A) General Conditions. Reimbursement for exodontic services includes payment for local anesthesia, suture removal, irrigations, spicule removal, apical curettage of associated cysts and granulomas, enucleation of associated follicles, and routine preoperative and postoperative care. The MassHealth agency pays for medically necessary routine extractions provided in an office, hospital (inpatient or outpatient setting), or a freestanding ambulatory surgery center. Use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center for extractions is limited to those members whose health, because of a medical condition, would be at risk if these procedures were performed in the provider's office. Member apprehension alone is not sufficient justification for use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Lack of facilities for the administration of general anesthesia when the procedure can be routinely performed with local anesthesia does not justify the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Many services listed in Appendix E of the *Dental Manual* are allowed in the office.

(B) Extraction. Extraction can be either the removal of soft tissue-retained coronal remnants of a deciduous tooth or the removal of an erupted tooth or exposed root by elevation and/or forceps including routine removal of tooth structure, minor smoothing of socket bone, and closure. The removal of root tips whose main retention is soft tissue is considered a simple extraction. All simple extractions may be performed as necessary. The MassHealth agency may investigate an unusually heavy use of simple extractions in the primary dentition to determine whether such extractions were medically necessary. The MassHealth agency does not pay for the extraction of deciduous teeth that appear from radiographic evaluation to be near exfoliation. Incision and drainage performed at the time of extraction is not reimbursable as a separate procedure.

(C) Surgical Removal of Erupted Tooth. The MassHealth agency pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to effect the extraction or the sectioning of a tooth. This may also include root tips if the reviewer determines that retention is more than soft tissue (that is, bone). The provider must maintain a preoperative radiograph of the erupted tooth in the member's dental record to substantiate the service performed. The MassHealth agency determines the necessity of surgical extraction from radiographs and clinical documentation in the member's dental record.

(D) Surgical Removal of Impacted Tooth. The MassHealth agency pays for the surgical removal of an impacted tooth. Surgical removal of a complete bony impacted tooth requires prior authorization. When prior authorization is requested for a surgical procedure in a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center, the provider must state the medical necessity and the particular complexity of the procedure that justifies the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Member apprehension alone is not sufficient justification for the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Lack of facilities for administering general anesthesia when the procedure can be routinely performed with local anesthesia does not justify use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(1) Circumstances under which the MassHealth agency pays for surgical removal of impacted teeth include but are not limited to:

(a) full bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length;

(b) teeth involving a cyst, tumor, or other neoplasm;

(c) unerupted teeth causing the resorption of roots of other teeth;

(d) partially erupted teeth that cause intermittent gingival inflammation; and

(e) perceptive radiologic pathology that fails to elicit symptoms.

(2) The provider must maintain a preoperative radiograph of the impacted tooth in the member's dental record to substantiate the service performed. The radiograph must clearly define the category of impaction. The MassHealth agency determines the degree of impaction from the radiographs and clinical records in the member's dental record.

(3) A root tip is not considered an impacted tooth.

(4) Surgical removal of a whole tooth with soft-tissue impaction is the removal of a tooth in which the occlusal surface of the tooth is covered by soft tissue requiring mucoperiosteal flap elevation for removal.

(5) Surgical removal of a whole tooth with partial bony impaction is the removal of a tooth in which part of the crown is covered by bone and requires mucoperiosteal flap elevation and bone excision for removal. Segmentalization of the tooth may be required.

(6) Surgical removal of a whole tooth with complete bony impaction is the removal of a tooth in which most or all of the crown is covered by bone and requires mucoperiosteal flap elevation, bone removal and possible segmentalization for removal. This service requires prior authorization.

(7) Surgical exposure of impacted or unerupted teeth to aid eruption requires prior authorization. The procedure is limited to members under 21 years of age for the exposure of impacted cuspids for orthodontic reasons. The MassHealth agency may request an orthodontic consultation as a result of the review of the request for prior authorization. The MassHealth agency does not pay for reexposure due to tissue overgrowth or lack of orthodontic intervention.

(E) Alveoplasty.

(1) The MassHealth agency pays for alveoplasty procedures performed in conjunction with the extraction of teeth.

(2) The MassHealth agency pays only once for the same quadrant alveoplasty (dentulous or edentulous) when performed within six months of initial alveoplasty.

(3) Alveoplasty does not require prior authorization for eligible members.

(F) Frenulectomy Frenulectomies may be performed to excise the frenum when the tongue has limited mobility, to aid in the closure of diastemas, and as a preparation for prosthetic surgery. Frenulectomy does not require prior authorization. If the purpose of the frenulectomy is to release a tongue, a written statement by a physician or primary care clinician and a speech pathologist clearly stating the problem must be maintained in the member's dental record. The MassHealth agency does not pay for labial frenulectomies performed before the eruption of the permanent cuspids, unless orthodontic documentation that clearly justifies the need for the procedure is maintained in the member's dental record.

(G) Excision of Hyperplastic Tissue. Excision of hyperplastic tissue requires prior authorization. This procedure is for the preprosthetic removal of such lesions as fibrous epuli or benign palatal hyperplasia. The MassHealth agency may request photographs or models as a result of the review of the request for prior authorization. The photographs and models as well as any related pathology report must be retained in the member's dental record.

(H) Postoperative Visits. Payment for routine postoperative visits is included in the fee for surgical procedures. This includes routine suture removal. Nonroutine postoperative follow-up in the office is an individual-consideration service that is reimbursable only for unusual services and only to ensure the safety and comfort of a postsurgical member. This nonroutine postoperative visit may include drain removal or packing change. A detailed report must be submitted for individual consideration in conjunction with the claim form for postoperative visit. The date, the location of the original surgery, and the type of procedure defines the report.

(130 CMR 420.430 and 420.431 Reserved)

420.432: Service Descriptions and Limitations: Introduction — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Service descriptions and limitations that are specific to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) are set forth in 130 CMR 420.433 through 420.439. Unless otherwise specified below, the service descriptions and limitations for services provided to such members are identical to the coverage for members under age 21 as set forth in 130 CMR 420.422 through 420.429. In addition, services that apply to all members, including members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D), are set forth in 130 CMR 420.452 through 420.457.

420.433: Service Descriptions and Limitations: Diagnostic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Diagnostic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described in 130 CMR 420.422(A) through (C), except that the only radiographs reimbursable with regard to an emergency care visit are those described and limited in 130 CMR 420.434.

420.434: Service Descriptions and Limitations: Radiographs — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Radiographic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.423, except as follows.

(A) Panoramic Films. The services described in 130 CMR 420.423(C)(2) are not reimbursable.

(B) Diagnostic Photographic Prints. Diagnostic photographic prints are not reimbursable unless otherwise requested by the MassHealth agency.

420.435: Service Descriptions and Limitations: Preventive Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Preventive services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.424, except as follows.

(A) Fluoride. The services described at 130 CMR 420.424(B)(1) and (2) are not reimbursable. The MassHealth agency pays for topical fluoride treatment for members who also have medical or dental conditions that significantly interrupt the flow of saliva, subject to prior authorization. The prior-authorization request must include documentation of such conditions that may include, but are not limited to, radiation therapy, tumors, certain drug treatments, such as some psychotropic medication, and certain diseases and injuries.

(B) Sealants and Mouth Guards. The services described in 130 CMR 420.424(E) and (G) are not reimbursable.

420.436: Service Descriptions and Limitations: Restorative Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Restorative services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.425, except as follows.

(A) Composite Resin Restorations. The services described in 130 CMR 420.425(B)(4), (6), and (7) are not reimbursable.

(B) Crowns, Posts, and Cores.

(1) The MassHealth agency pays for crowns on anterior teeth only, subject to the prior-authorization criteria set forth in 130 CMR 420.425(D)(1), (2), (4), (5), (6), and (8). Neither acrylic-jacket crowns nor stainless-steel or prefabricated resin crowns are reimbursable.

(2) The MassHealth agency does not pay for crowns for a posterior tooth unless extraction (the alternative treatment) would cause undue medical risk for a member with one or more specific medical conditions. The prior-authorization request must include documentation of these medical conditions, which include but are not limited to

(a) hemophilia;
(b) history of radiation therapy;
(c) acquired or congenital immune disorder;
(d) severe physical disabilities such as quadriplegia;
(e) profound mental retardation; and
(f) profound mental illness.

(C) Fixed Bridgework. The services described in 130 CMR 420.425(E) are not reimbursable.

420.437: Service Descriptions and Limitations: Endodontic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

The maximum allowable fee for endodontic services includes payment for all radiographs performed during the same treatment session. Endodontic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.426, except as follows.

(A) Pulpotomy. The services described in 130 CMR 420.426(A) are not reimbursable.

(B) Root Canal Therapy.

(1) The MassHealth agency pays for root-canal therapy on anterior teeth only.

(2) The MassHealth agency does not pay for root-canal therapy for a posterior tooth unless removable prosthodontics (the alternative treatment) would cause undue medical risk for a member with one or more specific medical conditions. The prior-authorization request must include documentation of these medical conditions, which include but are not limited to

(a) hemophilia;
(b) history of radiation therapy;
(c) acquired or congenital immune disorder;
(d) severe physical disabilities such as quadriplegia;
(e) profound mental retardation; and
(f) profound mental illness.

420.438: Service Descriptions and Limitations: Prosthodontic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Prosthodontic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.427, except as follows.

(A) Dentures. The services described in 130 CMR 420.427(A)(1)(b) and (d) are not reimbursable.

(B) Denture Treatment Plan and Prosthetic History. The fee for dentures includes payment for any relines necessary within 12 months after insertion of the denture.

(C) Full Dentures. The services described in 130 CMR 420.427(C)(2) are not reimbursable.

(D) Partial Dentures. The services described in 130 CMR 420.427(D)(6) are not reimbursable.

(E) Full-Denture Relines and Rebases. The fee for dentures includes payment for any relines necessary within 12 months of the dispensing date of the denture. Subsequent relines and rebases are reimbursable with prior authorization once every three years.

420.439: Service Descriptions and Limitations: Exodontic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Exodontic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.429(A) through (H), except that the services described in 130 CMR 420.429(D)(7) are not reimbursable.

420.440: Service Descriptions and Limitations: Introduction — Members Aged 21 and Older Who Are Either Pregnant or a Mother with a Child Under the Age of Three Years

The descriptions and limitations for services provided to pregnant women and to mothers with a child under the age of three years are the same as set forth in 130 CMR 420.432 through 420.439. Prior authorization is not required to verify that a member is either pregnant or a mother of a child under the age of three years. All other service limitations apply.

(130 CMR 420.441 Reserved)

420.442: Service Descriptions and Limitations: Introduction — Other Members Aged 21 and Older

Service descriptions and limitations that are specific to members aged 21 and older who do not meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) (other members aged 21 and older) are described in 130 CMR 420.443 through 420.449. In addition, services that apply to all members, including members aged 21 and older who do not meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D), are set forth in 130 CMR 420.452 through 420.457.

420.443: Service Descriptions and Limitations: Diagnostic Services — Other Members Aged 21 and Older

Except for emergency dental care, as described and limited in 130 CMR 420.422(C), diagnostic services are not reimbursable when provided to other members aged 21 and older; except that the only radiographs reimbursable with regard to an emergency care visit are those described in 130 CMR 420.444.

420.444: Service Descriptions and Limitations: Radiographs — Other Members Aged 21 and Older

Radiographic services that are reimbursable when provided to other members aged 21 and older consist of the following.

(A) Intraoral Films. The MassHealth agency pays for intraoral films as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements.

(1) Full-Mouth Radiographs. Full-mouth radiographs are reimbursable as a separate procedure when related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements. All other provisions of 130 CMR 420.423(B)(1)(a) apply.

(2) Bitewing Survey. The MassHealth agency pays for up to two bitewing films as a separate procedure when related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements. Bitewing films may not be billed separately when taken as part of a full-mouth series.

(3) Periapical Films. The MassHealth agency pays for periapical films. A maximum of four periapical films may be taken as a separate procedure when related to diagnosing an emergency-care condition, extracting a tooth, or to document a treatment related to prior-authorization requirements. Prior authorization is required for additional radiographs.

(B) Panoramic Films for Surgical Conditions. The service descriptions and limitations are identical to those set forth in 130 CMR 420.423(C)(1).

(C) Diagnostic Photographic Prints. Diagnostic photographic prints are not reimbursable unless otherwise requested by the MassHealth agency.

420.445: Service Descriptions and Limitations: Preventive Services — Other Members Aged 21 and Older

Preventive services are not reimbursable when provided to other members aged 21 and older, with the exception of the service described and limited in 130 CMR 420.435(A).

420.446: Service Descriptions and Limitations: Restorative Services — Other Members Aged 21 and Older

Restorative services are not reimbursable when provided to other members aged 21 and older, with the exception of the service described and limited in 130 CMR 420.449(B).

420.447: Service Descriptions and Limitations: Endodontic Services — Other Members Aged 21 and Older

(A) Endodontic services are not reimbursable when provided to other members aged 21 and older, with the exception of the service described and limited in 130 CMR 420.447(B).

(B) If an extraction of a tooth would cause undue medical risk for a member with one or more specific medical conditions listed below, the MassHealth agency will pay for root-canal therapy (the alternative treatment) for a tooth, subject to prior authorization. The prior-authorization request must include documentation of these medical conditions, which include, but are not limited to the following:

(1) hemophilia;
(2) history of radiation therapy;
(3) acquired or congenital immune disorder;
(4) severe physical disabilities such as quadriplegia;
(5) profound mental retardation; and
(6) profound mental illness.

420.448: Service Descriptions and Limitations: Prosthodontic Services — Other Members Aged 21 and Older

Prosthodontic services are not reimbursable when provided to other members aged 21 and older.

420.449: Service Descriptions and Limitations: Exodontic Services — Other Members Aged 21 and Older

(A) Exodontic services that are reimbursable when provided to other members aged 21 and older consist of all services described and limited in 130 CMR 420.429(A) through (H), except that the services described in 130 CMR 420.429(D)(7) are not reimbursable.

(B) In addition to the services described in 130 CMR 420.449(A), if the extraction of a tooth would cause undue medical risk for a member with one or more specific medical conditions listed below, with prior authorization, the MassHealth agency will pay for a crown (the alternative treatment). The prior-authorization request must include documentation of these medical conditions, which include, but are not limited to the following:

(1) hemophilia;
(2) history of radiation therapy;
(3) acquired or congenital immune disorder;
(4) severe physical disabilities such as quadriplegia;
(5) profound mental retardation; and
(6) profound mental illness.

(130 CMR 420.450 Reserved)

420.451: Service Descriptions and Limitations: Introduction — All Members

The service descriptions and limitations that apply to all members without exception are set forth in 130 CMR 420.452 through 420.457.

420.452: Service Descriptions and Limitations: General Anesthesia and IV Sedation — All Members

The following service descriptions and limitations apply to all members.

(A) General anesthesia or IV sedation is reimbursable without prior authorization when administered in the office only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral surgery services. All rules, regulations, and requirements set forth by the Massachusetts Board of Registration in Dentistry and by the Massachusetts Society of Oral and Maxillofacial Surgeons that apply to office general anesthesia, intravenous sedation, and the various forms of analgesia must be followed without exception. General anesthesia and IV sedation may only be used for oral surgery and maxillofacial procedures.

(B) The administration of analgesia (orally (PO), rectally (PR), inhalation nitrous oxide (N_2O/O_2)) and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure (see 130 CMR 420.413).

(C) A completed anesthesia flowsheet must be retained in the member's dental record. In addition, the provider must document the following in the member's dental record:

(1) the beginning and ending times of any general anesthesia or analgesia;
(2) preoperative, intraoperative, and postoperative vital signs;
(3) medications administered including their dosages and routes of administration;
(4) monitoring equipment utilized; and
(5) a statement of the member's response to the analgesic or anesthetic used including any complication or adverse reaction.

(D) Providers may claim payment for general anesthesia or IV sedation services for the first 30 minutes and then only in 15-minute increments thereafter, as set forth in the service descriptions in Subchapter 6 of the *Dental Manual.* Payment is limited to a maximum of 90 minutes.

420.453: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services — All Members

The following service descriptions and limitations apply to oral and maxillofacial surgery services provided to all members. Reimbursement for oral and maxillofacial surgery services is full payment for member care and includes payment for routine inpatient preoperative and postoperative care as well as for any related administrative or supervisory duties in connection with member care.

(A) Introduction. Reimbursable oral and maxillofacial surgery services consist of those basic surgical services essential for the prevention and control of diseases of the oral cavity and supporting structures and for the maintenance of oral health. The MassHealth agency pays only for those services consistent with the regulations in 130 CMR 420.000. Maxillofacial surgery services are reimbursable only for the purpose of anatomic and functional reconstruction of structures that are missing, defective, or deformed because of surgical intervention, trauma, pathology, or developmental or congenital malformations. Cosmetic benefit may result from such surgical services but cannot be the primary reason for those services.

(B) General Conditions. Only oral surgery specialists may claim payment for the services listed in Appendix E of the *Dental Manual* and only if proper certification is on file at the MassHealth agency's Provider Enrollment Unit. Oral surgery specialists may also bill for services listed throughout Subchapter 6 of the *Dental Manual*. Prior authorization is required if indicated next to the service description for the oral and maxillofacial surgical service. Services not listed in the *Dental Manual* are not covered by the MassHealth agency. In no instance does the MassHealth agency pay for new procedures or materials that are not within the scope of standard clinical practice, nor does it pay for procedures considered experimental. In general, most service codes allow for the delivery in the office location where feasible and considered safe for the member. Most routine dentoalveolar surgery requires prior authorization for hospital admission or treatment except for extractions and dentulous alveoplasties.

(C) Orthognathic Surgery.

(1) Orthognathic surgery requires prior authorization. Requests for prior authorization must include at least the following:

(a) a full dental and surgical treatment plan;
(b) documentation of orthodontic consultation;
(c) full-mouth radiographs;
(d) preoperative models;
(e) preoperative cephalometric film with tracing;
(f) projected cephalometric analysis; and
(g) photographs of the face and teeth from the AP (anterior and posterior) and lateral projections.

(2) The prior-authorization request must include a complete and precise description of the requested surgical procedures and the necessity of progressive procedures (staging), if anticipated. The request must explain the medical necessity of these procedures. The MassHealth agency does not pay for orthognathic surgery performed for cosmetic or experimental reasons. Any proposed orthodontic treatment must meet all the criteria described at 130 CMR 420.428.

420. 454: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Procedures — All Members

The following service descriptions and limitations apply to all members. Most oral and maxillofacial surgery codes allow for the office location where technically feasible and safe for the member. Use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center is mandatory in major maxillofacial surgery such as multiple trauma and orthognathic surgery. The MassHealth agency pays for the use of such settings when it is justified by the difficulty of the surgery (for example, four deep bony impactions) in addition to the medical health of the member (for example, asthmatic on multiple medications, alcoholism, or drug history, seizure disorder, or developmentally disabled). Member fear or apprehension does not justify the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(A) Utilization Management Program. The MassHealth agency pays for procedures and hospital stays that are subject to the Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207 through 450.209 are satisfied. Appendix G of the *Dental Manual* contains the name, address, and telephone number of the contact organization for the screening program and describes the information that must be provided as part of the review process.

(B) Surgical Assistants. Payment to surgical assistants is 15 percent of the allowable fee for the procedure performed, with a minimum payment of $20.00.

(C) Preoperative Diagnosis and Postoperative Care. For surgery procedures performed in a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center, the fees include payment for preoperative diagnosis and postoperative care during the member's stay and are the maximum allowable amounts.

(D) Inpatient Visits. The MassHealth agency pays providers for visits to hospitalized members except for routine preoperative and postoperative care to members who have undergone or who are expected to undergo surgery. Inpatient visits are reimbursable only under exceptional circumstances such as with preoperative or postoperative complications or the need for extended care, prolonged attention, intensive-care services, or consultation services. Prior authorization is not required; however, the provider must substantiate the need for this service in the member's hospital medical record.

(E) Multiple Procedures.

(1) The MassHealth agency does not pay separately for the component parts of a major, more comprehensive service when they are performed on the same date as the comprehensive service. Payment for a comprehensive service includes any separately identified component parts of the comprehensive service, even when separate service codes exist for the component parts. For example, the provider may not claim payment for a frenulectomy performed at the time of a full vestibuloplasty with graft.

(2) Where two or more individual procedures are performed in the same operative session, the procedure with the largest fee-schedule amount is payable at the full amount, and each additional procedure is payable at 50 percent of the amount. This requires the use of modifiers and applies only to numeric service codes listed in Appendix E of the *Dental Manual*.

420.455: Service Descriptions and Limitations: Maxillofacial Prosthetics — All Members

The following service descriptions and limitations apply to maxillofacial prosthetic services provided to all members.

(A) Payment for maxillofacial prosthetics is limited to dental practitioners who have completed a training program in maxillofacial prosthetics. Payment for maxillofacial prosthetics requires prior authorization and is reviewed on an individual-consideration basis. The MassHealth agency approves requests only if the maxillofacial prosthetic device will be constructed for the treatment of a member with congenital, developmental, or acquired defects of the mandible or maxilla and associated structures.

(B) A detailed description of the defect and the proposed device must be submitted with a request for prior authorization and must provide sufficient information and justification for the MassHealth agency to determine the medical necessity and appropriateness of the device. A photograph of the defect and the device may be required.

(C) The MassHealth agency pays for opposing appliances only when they are necessary for the balance or retention of the primary maxillofacial prosthetic device.

420.456: Service Descriptions and Limitations: Other Services — All Members

The following service descriptions and limitations apply to all members.

(A) Admission of Members with Certain Disabilities for Restorative, Endodontic, or Exodontic Dentistry.

(1) A severely and persistently mentally ill or physically or developmentally disabled member, under certain circumstances, may undergo restorative, endodontic, or exodontic dental procedures for which they are eligible in a hospital (inpatient or outpatient setting) or in a freestanding ambulatory surgery center. The use of these facilities for restorative, endodontic, or exodontic dentistry requires prior authorization. Use of these facilities may be indicated for a member who

(a) has a condition that is reasonably likely to place the member at risk of medical complications that require medical resources that are not available in an office setting;
(b) is extraordinarily uncooperative, fearful, or anxious;
(c) is an uncommunicative child or adolescent with dental needs requiring immediate attention;
(d) has dental needs but for which local anesthesia is ineffective due to acute infection, idiosyncratic anatomy, or allergy; or
(e) has sustained orofacial or dental trauma, or both, so extensive that treatment cannot be provided safely and effectively in an office setting.

(2) Requests for prior authorization of restorative, endodontic, or exodontic services in such settings must include the following:

(a) a detailed description of the member's illness or disability;
(b) a history of previous treatment or attempts at treatment;
(c) a treatment plan listing all procedures and the teeth involved;
(d) radiographs (if radiographs are not available, an explanation is required);
(e) photographs to indicate the condition of the mouth if radiographs are not available; and
(f) documentation that there is no other suitable site of service for the member that would be less costly to the MassHealth agency.

(3) Ordinary fear, ordinary apprehension, or age alone does not justify admission to a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(B) Oral Screenings for Members Undergoing Radiation Treatment or Chemotherapy.

(1) Members undergoing radiation, chemotherapy, or both, or who are on long-term immunosuppressive therapy may require oral screenings.

(2) Oral screenings are reimbursed under a global fee. The global fee for oral screenings includes the following:

(a) comprehensive oral examination;
(b) consultation;
(c) salivary flow measurements;
(d) oral hygiene evaluations and instructions;
(e) fluoride treatments;
(f) construction of fluoride trays;
(g) follow-up examination; and
(h) follow-up salivary evaluations.

420.457: Dental Management of Members with Certain Disabilities in the Office

(A) Payment of an additional fee for management of a severely and persistently mentally ill or physically or developmentally disabled member in the office requires prior authorization. The request for prior authorization must contain the following:

(1) a clear statement of the member's illness or disability
(2) a history of treatment or previous attempts at treatment;
(3) the types of services to be furnished; and
(4) any anesthetic agents to be used.

(B) For payment of the additional fee for emergency palliative treatment of dental pain, the provider may request prior authorization after the provision of the service, if such authorization is requested before billing.

REGULATORY AUTHORITY

130 CMR 420.000: M.G.L. c. 118E, §§ 7 and 12.

The dental service codes and descriptions that are listed in this Subchapter 6 must be used when providing dental services to MassHealth members. For each dental service code, the description indicates any limitations, such as age, pregnancy, or special circumstances designation, subject to the Early and Periodic Screening, Diagnosis and Treatment provisions set forth at 130 CMR 450.144(A), provide for prior authorization for medically necessary unlisted or noncovered services for members under age 21.

Note that prior authorization may be requested for unlisted or noncovered services and codes for members under age 21, pursuant to 130 CMR 450.144(A).

601 Explanation of Abbreviations

The following abbreviations are used in Subchapter 6.

(A) **P.A.** indicates that service-specific prior authorization is required (see 130 CMR 420.410).

(B) **I.C.** indicates that the claim will receive individual consideration to determine payment. A descriptive report must accompany the claim (see 130 CMR 420.412).

(C) **S.P**. indicates that the procedure is commonly performed as part of a total service and does not usually warrant a separate fee. The procedure must be performed separately to receive the separate fee (see 130 CMR 420.413).

(D) **S.C.** indicates that the procedure is covered for members aged 21 and older who meet the Special Circumstances criteria (see 130 CMR 420.410(D)).

(E) **P.W.** indicates that the procedure is covered for members aged 21 and older who are either pregnant or a mother with a child under the age of three years.

602 Service Codes and Descriptions: Diagnostic Services

See 130 CMR 420.422, 420.433, 420.443 and 420.456 for limitations.

Service Code	Service Description
	Clinical Oral Evaluation
D0120	Periodic oral examination (twice per 12-month period) **(under 21, P.W., and S.C. only)**
D0150	Comprehensive oral evaluation—new or established patient (once per member per dentist) **(under 21, P.W., and S.C. only)**
D0160	Detailed and extensive oral evaluation—problem focused, by report (to be billed only for oral screening for members undergoing radiation treatment, chemotherapy, or organ transplant)

603 Service Codes and Descriptions: Radiographs

See 130 CMR 420.423, 420.434, and 420.444 for limitations.

Service Code	Service Description
	Radiographs
D0210	Intraoral—complete series (including bitewings) (once every three calendar years) **(ages 6 through 12**: 10 intraoral films and two posterior bitewings) **(ages 13 through 20**: minimum of 10 periapical films and two posterior bitewings) **(P.W. and S.C.**: minimum of 10 periapical films and two posterior bitewings) **(21 & older—other**: minimum of 10 periapical films and two posterior bitewings as separate procedure when related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to PA requirements)
D0220	Intraoral—periapical, first film
D0230	Intraoral—periapical, each additional film
D0270	Bitewing—single film
D0272	Bitewings—two films **(under 21, P.W., and S.C.,** twice per calendar year) **(21 and older — other,** limited as noted above)
D0274	Bitewings—four films (**under 21, P.W., and S.C. only,** twice per calendar year)
D0330	Panoramic film (nonsurgical condition—**under 21 only**) (surgical conditions—**all members)**
D0340	Cephalometric film **(under 21 only)** (P.A.)
D0350	Oral/facial photographic images (includes intra- and extraoral images) (excludes conventional radiographs) (only when requested by MassHealth to support a P.A. request for another service)
	Test and Laboratory Examinations
D0470	Diagnostic casts (only when requested by MassHealth) (PA)

604 Service Codes and Descriptions: Preventive Services

See 130 CMR 420.424, 420.435, and 420.445 for limitations.

Service Code	Service Description
	Dental Prophylaxis (twice per 12-month period)
D1110	Prophylaxis—adult **(ages 14 through 20, P.W., and S.C. only)**
D1120	Prophylaxis—child **(to age 14)**
	Topical Fluoride Treatment (Office Procedure)
D1203	Topical application of fluoride (prophylaxis not included)—child **(under 21 only) (P.W., S.C. and 21 and older—other require P.A.)**

604 Service Codes and Descriptions: Preventive Services (cont.)

Other Preventive Services

D1351 Sealant—per tooth (primary or permanent first and second noncarious molars, first and second non-carious bicuspids (premolars) with deep pits and fissures, and noncarious third molars with deep pits and fissures) (once per three years per tooth) **(under 21 only)**

Space Maintenance (Passive Appliances)

D1510 Space maintainer—fixed-unilateral **(under 21 only)**
D1515 Space maintainer—fixed-bilateral **(under 21 only)**
D1520 Space maintainer—removable unilateral **(under 21 only)**
D1525 Space maintainer—removable-bilateral **(under 21 only)**
D1550 Recementation of space maintainer **(under 21 only)**

605 Service Codes and Descriptions: Restorative Services

See 130 CMR 420.425, 420.436, and 420.446 for limitations.

Service Code	Service Description

Amalgam Restorations (Including Polishing)

D2140 Amalgam—one surface, primary or permanent **(primary—under 21 only) (permanent—under 21, P.W., and S.C. only)**
D2150 Amalgam—two surfaces, primary or permanent **(primary—under 21 only) (permanent—under 21, P.W., and S.C. only)**
D2160 Amalgam—three surfaces, primary or permanent **(primary—under 21 only) (permanent—under 21, P.W., and S.C. only)**
D2161 Amalgam—four or more surfaces, primary or permanent **(under 21, P.W., and S.C. only)**

Resin Restorations (Composite Restorations)

D2330 Resin-based composite—one surface, anterior **(under 21, P.W., and S.C. only)**
D2331 Resin-based composite—two surfaces, anterior **(under 21, P.W., and S.C. only)**
D2332 Resin-based composite—three surfaces, anterior **(under 21 only)**
D2335 Resin-based composite—four or more surfaces or involving incisal angle (anterior) (for fractured incisal angle) (includes pins) **(under 21 only)**
D2390 Resin-based composite crown, anterior **(under 21 only)**
D2391 Resin-based composite—one surface, posterior **(primary—under 21 only) (permanent—under 21, P.W., and S.C. only)**
D2392 Resin-based composite—two surfaces, posterior **(primary—under 21 only) (permanent—under 21, P.W., and S.C. only)**
D2393 Resin-based composite—three surfaces, posterior **(primary—under 21 only) (permanent—under 21, P.W., and S.C. only)**
D2394 Resin-based composite—four or more surfaces, posterior **(primary—under 21 only) (permanent—under 21, P.W., and S.C. only)**

605 Service Codes and Descriptions: Restorative Services (cont.)

Crowns—Single Restoration Only

D2710 Crown—resin-based composite (indirect) **(under 21 only)** (P.A.)
D2751 Crown—porcelain fused to predominantly base metal **(under 21, P.W., and S.C. only)** (P.A.)

Other Restorative Services

D2910 Recement inlay, onlay or partial coverage restoration **(under 21, P.W., and S.C. only)**
D2920 Recement crown **(under 21, P.W., and S.C. only)**
D2930 Prefabricated stainless steel crown—primary tooth **(under 21 only)**
D2931 Prefabricated stainless steel crown—permanent tooth **(under 21 only)**
D2932 Prefabricated resin crown (primary anterior teeth only) **(under 21 only)**
D2951 Pin retention—per tooth, in addition to restoration (two or more surfaces) (commercial amalgam bonding) **(under 21, P.W., and S.C. only)**
D2954 Prefabricated post and core in addition to crown **(under 21, P.W., and S.C. only)** (P.A.)
D2980 Crown repair, by report **(under 21, P.W., and S.C. only)** (P.A.)
D2999 Unspecified restorative procedure, by report **(under 21, P.W., and S.C. only)** (P.A.) (I.C.)

606 Service Codes and Descriptions: Endodontic Services

See 130 CMR 420.426, 420.437, and 420.447 for limitations.

Service Code — Service Description

Pulpotomy

D3220 Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament **(under 21 only)**

Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)

D3310 Anterior (excluding final restoration) **(under 21, P.W., and S.C. only)** (P.A.) (no limitation on number performed per treatment period)
D3320 Bicuspid (excluding final restoration) (**under 21 only**) (P.A.) (no limitation on number performed per treatment period)
D3330 Molar (excluding final restoration) (**under 21 only**) (P.A.) (no limitation on number performed per treatment period)

Apicoectomy/Periradicular Services

D3410 Apicoectomy/periradicular surgery—anterior (per tooth) (includes retrograde filling) **(under 21, P.W., and S.C. only)** (P.A.)
D3421 Apicoectomy/periradicular surgery—bicuspid (first root) **(under 21, P.W., and S.C. only)** (P.A.)
D3426 Apicoectomy/periradicular surgery (each additional root) **(under 21, P.W., and S.C. only)** (P.A.)

607 Service Codes and Descriptions: Periodontic Services

See 130 CMR 420.424, 420.435, and 420.445 for limitations.

Service Code	Service Description
	Surgical Services (Including Usual Postoperative Services)
D4210	Gingivectomy or gingivoplasty—four or more contiguous teeth or bounded teeth spaces per quadrant (once per quadrant per three-year period) **(under 21, P.W., and S.C. only)** (P.A.)
D4341	Periodontal scaling and root planing—four or more teeth per quadrant (includes curettage) (once per quadrant per three-year period) **(under 21, P.W., and S.C. only)** (P.A.)

608 Service Codes and Descriptions: Prosthodontic (Removable) Services

See 130 CMR 420.427, 420.438, and 420.448 for limitations.

Service Code	Service Description
	Complete Dentures (Including Routine Post-Delivery Care)
D5110	Complete denture—maxillary **(under 21, P.W., and S.C. only)** (P.A.)
D5120	Complete denture—mandibular **(under 21, P.W., and S.C. only)** (P.A.)
D5130	Immediate denture—maxillary **(under 21 only)** (P.A.)
D5140	Immediate denture—mandibular **(under 21 only)** (P.A.)
	Partial Dentures (Including Routine Post-Delivery Care)
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests, and teeth) **(under 21, P.W., and S.C. only)** (P.A.)
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests, and teeth) **(under 21, P.W., and S.C. only)** (P.A.)
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) **(under 21 only)** (P.A.)
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) **(under 21 only)** (P.A.)
	Repairs to Complete Dentures
D5510	Repair broken complete denture base **(under 21, P.W., and S.C. only)**
D5520	Replace missing or broken teeth—complete denture (each tooth) **(under 21, P.W., and S.C. only)**

608 Service Codes and Descriptions: Prosthodontic (Removable) Services (cont.)

Repairs to Partial Dentures

D5610 Repair resin denture base **(under 21, P.W., and S.C. only)**
D5620 Repair cast framework **(under 21, P.W., and S.C. only)**
D5630 Repair or replace broken clasp **(under 21, P.W., and S.C. only)**
D5640 Replace broken teeth—per tooth **(under 21, P.W., and S.C. only)**
D5650 Add tooth to existing partial denture **(under 21, P.W., and S.C. only)**
D5660 Add clasp to existing partial denture **(under 21, P.W., and S.C. only)**

Denture Rebase Procedures

D5710 Rebase complete maxillary denture **(under 21, P.W., and S.C. only)** (P.A.)
D5711 Rebase complete mandibular denture **(under 21, P.W., and S.C. only)** (P.A.)
D5720 Rebase maxillary partial denture (cast partial denture only) **(under 21 only)** (P.A.)
D5721 Rebase mandibular partial denture (cast partial denture only) **(under 21 only)** (P.A.)

Denture Reline Procedures

D5750 Reline complete maxillary denture (laboratory) **(under 21, P.W., and S.C. only)** (P.A.)
D5751 Reline complete mandibular denture (laboratory) **(under 21, P.W., and S.C. only)** (P.A.)
D5760 Reline maxillary partial denture (laboratory) (cast partial denture only) **(under 21, PW and S.C. only)** (P.A.)
D5761 Reline mandibular partial denture (laboratory) (cast partial denture only) **(under 21, PW and S.C. only)** (P.A.)

609 Service Codes and Descriptions: Prosthodontic (Fixed) Services

See 130 CMR 420.427, 420.438, and 420.448 for limitations. Each abutment and each pontic constitutes a unit in a bridge.

Service Code	Service Description

Fixed Partial Denture Pontics

D6241 Pontic—porcelain fused to predominantly base metal **(under 21 only**) (P.A.)
D6751 Crown—porcelain fused to predominantly base metal **(under 21 only)** (P.A.)

Other Fixed Partial Denture Services

D6930 Recement fixed partial denture **(ages 16 through 20 only**)
D6980 Fixed partial denture repair, by report **(ages 16 through 20 only**) (P.A.)
D6999 Unspecified, fixed prosthodontic procedure, by report **(under 21, P.W., and S.C. only)** (P.A.) (I.C.)

610 Service Codes and Descriptions: Exodontic Services

See 130 CMR 420.429, 420.439, and 420.449 for limitations.

Service Code	Service Description
	Extractions (Includes Local Anesthesia and Routine Postoperative Care)
D7111	Extraction, coronal remnants—deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth—soft tissue
D7230	Removal of impacted tooth—partially bony
D7240	Removal of impacted tooth—completely bony (P.A.)
D7280	Surgical access of an unerupted tooth **(under 21 only)** (P.A.)
D7283	Placement of device to facilitate eruption of impacted tooth **(under 21 only)** (P.A.)
	Surgical Procedures
D7310	Alveoplasty in conjunction with extractions—per quadrant
D7311	Alveoplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant (I.C.)
D7320	Alveoplasty not in conjunction with extractions—per quadrant
D7321	Alveoplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant (I.C.)
D7340	Vestibuloplasty—ridge extension (second epithelialization) (P.A.)
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7960	Frenulectomy (frenectomy or frenotomy)—separate procedure (S.P.)
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue—per arch (P.A.)
D7999	Unspecified oral surgery procedure, by report (P.A.) (I.C.)
D9930	Treatment of complications (postsurgical)—unusual circumstances, by report (I.C.)

611 Service Codes and Descriptions: Orthodontic Services

See 130 CMR 420.428 for limitations.

Service Code	Service Description
	Orthodontic Diagnosis and Full Orthodontic Treatment
D8080	Comprehensive orthodontic treatment of the adolescent dentition **(under 21 only)** (P.A.)
D8660	Pre-orthodontic treatment visit (consultation) (accredited orthodontists only) (once per six months) **(under 21 only)**
D8670	Periodic orthodontic treatment visit (as part of contract) (full orthodontic treatment, active, first year and second year, and first half of third year, if necessary, including retainer—quarterly treatment visits) **(under 21 only)** (P.A.)
D8690	Orthodontic treatment (alternative billing to a contract fee) **(under 21 only)** (P.A.)

611 Service Codes and Descriptions: Orthodontic Services (cont.)

Other Orthodontic Services

D8680 Orthodontic retention (removal of appliances, construction and replacement of retainer(s)) **(under 21 only)**
D8692 Replacement of lost or broken retainer **(under 21 only)** (P.A.)
D8999 Unspecified orthodontic procedure, by report **(under 21 only)** (P.A.) (I.C.)

612 Service Codes and Descriptions: General Anesthesia and IV Sedation Services — All Members

See 130 CMR 420.452 for limitations. The allowable fees include payment for cardiac monitoring and other related costs, per 15 minutes.

Service Code	Service Description
D9220	Deep sedation/general anesthesia—first 30 minutes
D9221	Deep sedation/general anesthesia—each additional 15 minutes (from 31 to 90 minutes)

613 Service Codes and Descriptions: Other Services — All Members

See 130 CMR 420.456 and 420.457 for limitations.

Service Code	Service Description
	Treatment of Physically or Developmentally Disabled Members
D9920	Behavior management, by report (P.A.)
	Unclassified Treatment
D9110	Palliative (emergency) treatment of dental pain—minor procedure (Other nonemergency medically necessary treatment may be provided during the same visit—that is, nonemergency codes may be billed in conjunction with D9110.)
D9940	Occlusal guard, by report **(under 21 only)** (P.A.)
D9941	Fabrication of athletic mouthguard **(under 21 only)**
D9999	Unspecified adjunctive procedure, by report (P.A.) (I.C.)

The **all-numeric** service codes that are listed in this appendix may be used when providing services to members in all categories of assistance, including category 4 (EAEDC), and may only be used by oral and maxillofacial surgeons who have submitted proof of certification to MassHealth. **The alphanumeric codes in Sections 621, 622, and 623** may not be used for services provided to category 4 members, with the exception of Service Code D7999.

Note that prior authorization may be requested for unlisted or noncovered services and codes for members under age 21, pursuant to 130 CMR 450.144(A).

620 Service Codes and Descriptions: Medical Services

Service Code	Service Description

OFFICE OR OTHER OUTPATIENT SERVICES

New Patient

99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a problem focused history; - a problem focused examination; and - straightforward medical decision making
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - an expanded problem-focused history; - an expanded problem-focused examination; and - straightforward medical decision making
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a detailed history; - a detailed examination; and - medical decision making of low complexity
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a comprehensive history; - a comprehensive examination; and - medical decision making of a moderate complexity
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity

Established Patient

99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components (does not include dentoalveolar diagnosis): - a problem-focused history; - a problem-focused examination; and - straightforward medical decision making

620 Service Codes and Descriptions: Medical Services (cont.)

INITIAL HOSPITAL CARE

New or Established Patient

99221 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:
- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity

SUBSEQUENT HOSPITAL CARE

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:
- a problem-focused interval history;
- a problem-focused examination;
- medical decision making that is straightforward or of low complexity

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:
- an expanded problem-focused interval history;
- an expanded problem-focused examination;
- medical decision making of moderate complexity

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:
- a detailed interval history;
- a detailed examination;
- medical decision making of high complexity

INITIAL INPATIENT CONSULTATIONS

New or Established Patient

99251 Initial inpatient consultation for a new or established patient, which requires these three key components:
- a problem-focused history;
- a problem-focused examination; and
- straightforward medical decision making

620 Service Codes and Descriptions: Medical Services (cont.)

Service Code	Service Description
99252	Initial inpatient consultation for a new or established patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - straightforward medical decision making
99253	Initial inpatient consultation for a new or established patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of low complexity
99254	Initial inpatient consultation for a new or established patient, which requires three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity
99255	Initial inpatient consultation for a new or established patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity

EMERGENCY DEPARTMENT SERVICES

New or Established Patient

99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - a problem-focused history; - a problem-focused examination; and - straightforward medical decision making
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - medical decision making of low complexity

620 Service Codes and Descriptions: Medical Services (cont.)

Service Code	Service Description
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - medical decision making of moderate complexity
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of moderate complexity
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity

621 Service Codes and Descriptions: Endodontic Services

See 130 CMR 420.426, 420.437, and 420.447 for limitations.

Service Code	Service Description
	Periapical Services
D3410	Apicoectomy/periradicular surgery—anterior (per tooth) (includes retrograde filling) **(under 21, P.W., and S.C. only)** (P.A.)
D3421	Apicoectomy/periradicular surgery—bicuspid (first root) **(under 21, P.W., and S.C. only)** (P.A.)
D3426	Apicoectomy/periradicular surgery (each additional root) **(under 21, P.W., and S.C. only)** (P.A.)

622 Service Codes and Descriptions: Exodontic Services

See 130 CMR 420.429, 420.439, and 420.449 for limitations.

Service Code	Service Description
	Extractions (including local anesthesia, suture removal, and routine postoperative care)
D7111	Extraction, coronal remnants—deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth—soft tissue
D7230	Removal of impacted tooth—partially bony
D7240	Removal of impacted tooth—completely bony (P.A.)

623 Service Codes and Descriptions: Oral and Maxillofacial Surgical Services

Service Code	Service Description
	Introduction
D7280	Surgical access of an unerupted tooth **(under 21 only)** (P.A.)
	Surgical Procedures
D7310	Alveoplasty in conjunction with extractions—per quadrant
D7311	Alveoplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant (I.C.)
D7320	Alveoplasty not in conjunction with extractions—per quadrant
D7321	Alveoplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant (I.C.)
D7340	Vestibuloplasty—ridge extension (second epithelialization) (P.A.)
D7350	Vestibuloplasty—ridge extension (including soft-tissue grafts, muscle reattachments, revision of soft-tissue attachment, and management of hypertrophied and hyperplastic tissue) (P.A.)
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor—lesion diameter up to 1.25 cm
D7451	lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor—lesion diameter up to 1.25 cm
D7461	lesion diameter greater than 1.25 cm
D7471	Removal of lateral exostosis (maxilla or mandible) (P.A.)
D7960	Frenulectomy (frenectomy or frenotomy)—separate procedure
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue—per arch (P.A.)
D7999	Unspecified oral surgery procedure, by report (P.A.) (I.C.)
D9930	Treatment of complications (postsurgical)—unusual circumstances, by report (I.C.)
	Unclassified Treatment
D9110	Palliative (emergency) treatment of dental pain—minor procedure (Other nonemergency medically necessary treatment may be provided during the same visit—that is, nonemergency codes may be billed in conjunction with D9110.)
D9999	Unspecified adjunctive procedure, by report (P.A.) (I.C.)

624 Service Codes and Descriptions: Surgical Services

See 130 CMR 420.451 for limitations.

Service Code	Service Description
	INTEGUMENTARY SYSTEM
	SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES
	Incision and Drainage
10060	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061	complicated or multiple
10120	Incision and removal of foreign body, subcutaneous tissues; simple
10121	complicated
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
	Excision—Debridement
11010	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues
11011	skin, subcutaneous tissue, muscle fascia, and muscle
11012	skin, subcutaneous tissue, muscle fascia, muscle, and bone
11040	Debridement; skin, partial thickness
11041	skin, full thickness
11042	skin and subcutaneous tissue
11043	skin, subcutaneous tissue, and muscle
11044	skin, subcutaneous tissue, muscle, and bone
	Biopsy
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
11101	each separate/additional lesion (List separately in addition to code for primary procedure.)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Shaving of Epidermal or Dermal Lesions
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311	lesion diameter 0.6 to 1.0 cm
11312	lesion diameter 1.1 to 2.0 cm
11313	lesion diameter over 2.0 cm
	Excision—Benign Lesions
11440	Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	excised diameter 0.6 to 1.0 cm
11442	excised diameter 1.1 to 2.0 cm
11443	excised diameter 2.1 to 3.0 cm
11444	excised diameter 3.1 to 4.0 cm
11446	excised diameter over 4.0 cm
	Excision—Malignant Lesions
11640	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less
11641	excised diameter 0.6 to 1.0 cm
11642	excised diameter 1.1 to 2.0 cm
11643	excised diameter 2.1 to 3.0 cm
11644	excised diameter 3.1 to 4.0 cm
11646	excised diameter over 4.0 cm
	MISCELLANEOUS
	Introduction
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	REPAIR (CLOSURE)
	Repair—Simple
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
12013	2.6 cm to 5.0 cm
12014	5.1 cm to 7.5 cm
12015	7.6 cm to 12.5 cm
12016	12.6 cm to 20.0 cm
12017	20.1 cm to 30.0 cm
12018	over 30.0 cm
12020	Treatment of superficial wound dehiscence; simple closure
12021	with packing
	Repair—Intermediate
12051	Layer closure of wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
12052	2.6 cm to 5.0 cm
12053	5.1 cm to 7.5 cm
12054	7.6 cm to 12.5 cm
12055	12.6 cm to 20.0 cm
12056	20.1 cm to 30.0 cm
12057	over 30.0 cm
	Repair—Complex
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 1.1 cm to 2.5 cm
13132	2.6 cm to 7.5 cm
13133	each additional 5 cm or less (List separately in addition to code for primary procedure.)
13150	Repair, complex, eyelids, nose, ears, and/or lips; 1.0 cm or less
13151	1.1 cm to 2.5 cm
13152	2.6 cm to 7.5 cm
13153	each additional 5 cm or less (List separately in addition to code for primary procedure.)
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Adjacent Tissue Transfer or Rearrangement
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10 sq cm or less
14041	defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, and/or lips; defect 10 sq cm or less
14061	defect 10.1 sq cm to 30.0 sq cm
	Free Skin Grafts
15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
15121	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure.)
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less
15241	each additional 20 sq cm (List separately in addition to code for primary procedure.)
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15261	each additional 20 sq cm (List separately in addition to code for primary procedure.)
	Flaps (Skin and/or Deep Tissues)
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	scalp, arms, or legs
15574	forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet
15576	eyelids, nose, ears, lips, or intraoral
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet
15630	at eyelids, nose, ears, or lips
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (e.g., temporalis, masseter muscle, sternocleidomastoid, levator scapulae)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Other Flaps and Grafts
15770	Graft; derma-fat-fascia
	Other Procedures
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid (P.A.)
15821	with extensive herniated fat pad (P.A.)
15822	Blepharoplasty, upper eyelid (P.A.)
15823	with excessive skin weighting down lid (P.A.)
15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
15841	free muscle graft (including obtaining graft)
15842	free muscle flap by microsurgical technique
15845	regional muscle transfer
	Burns, Local Treatment
16000	Initial treatment, first degree burn, when no more than local treatment is required
	DESTRUCTION
	Destruction, Benign or Premalignant Lesions
17000	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
17003	second through 14 lesions, each (List separately in addition to code for first lesion.)
17004	15 or more lesions
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Destruction, Malignant Lesions, Any Method
17280	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
17281	lesion diameter 0.6 to 1.0 cm
17282	lesion diameter 1.1 to 2.0 cm
17283	lesion diameter 2.1 to 3.0 cm
17284	lesion diameter 3.1 to 4.0 cm
17286	lesion diameter over 4.0 cm
	Other Procedures
17999	Unlisted procedure, skin, mucous membrane, and subcutaneous tissue (I.C.)
	MUSCULOSKELETAL SYSTEM
	GENERAL
	Incision
20000	Incision of soft tissue abscess (e.g., secondary to osteomyelitis); superficial
20005	deep or complicated
	Excision
20200	Biopsy, muscle; superficial
20205	deep
20206	Biopsy, muscle, percutaneous needle
20220	Biopsy, bone, trocar, or needle; superficial (e.g., ilium, sternum, spinous process, ribs)
20240	Biopsy, bone, open; superficial (e.g., ilium, sternum, spinous process, ribs, trochanter of femur)
20245	deep (e.g., humerus, ischium, femur)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Introduction or Removal
20520	Removal of foreign body in muscle or tendon sheath; simple
20525	deep or complicated
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)
20615	Aspiration and injection for treatment of bone cyst
20670	Removal of implant; superficial (e.g., buried wire, pin, or rod) (separate procedure)
20680	deep (e.g., buried wire, pin, screw, metal band, nail, rod, or plate)
20690	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
20692	Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (e.g., Ilizarov, Monticelli type)
20693	Adjustment or revision of external fixation system requiring anesthesia (e.g., new pin(s) or wire(s) and/or new ring(s) or bar(s))
20694	Removal, under anesthesia, of external fixation system
	Grafts (or Implants)
20900	Bone graft, any donor area; minor or small (e.g., dowel or button)
20902	major or large
20910	Cartilage graft; costochondral
20912	nasal septum
20920	Fascia lata graft; by stripper
20922	by incision and area exposure, complex or sheet
20924	Tendon graft, from a distance (e.g., palmaris, toe extensor, plantaris)
20926	Tissue grafts, other (e.g., paratenon, fat, dermis)
	Other Procedures
20955	Bone graft with microvascular anastomosis; fibula
20956	iliac crest
20962	other than fibula, iliac crest, or metatarsal
20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe
20970	iliac crest
20999	Unlisted procedure, musculoskeletal system, general (I.C.)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	HEAD
	Incision
21010	Arthrotomy, temporomandibular joint
	Excision
21015	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of face or scalp
21025	Excision of bone (e.g., for osteomyelitis or bone abscess); mandible
21026	facial bone(s)
21029	Removal by contouring of benign tumor of facial bone (e.g., fibrous dysplasia)
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031	Excision of torus mandibularis
21032	Excision of maxillary torus palatinus
21034	Excision of malignant tumor of maxilla or zygoma
21040	Excision of benign tumor or cyst of mandible; by enucleation and/or curettage
21044	Excision of malignant tumor of mandible
21045	radical resection
21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))
21047	requiring extra-oral osteotomy and partial mandibulectomy (e.g., locally aggressive or destructive lesion(s))
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))
21049	requiring extra-oral osteotomy and partial maxillectomy (e.g., locally aggressive or destructive lesion(s))
21050	Condylectomy, temporomandibular joint (separate procedure)
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
21070	Coronoidectomy (separate procedure)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Introduction or Removal
21076	Impression and custom preparation; surgical obturator prosthesis (P.A.)
21077	orbital prosthesis (P.A.)
21079	interim obturator prosthesis (P.A.)
21080	definitive obturator prosthesis (P.A.)
21081	mandibular resection prosthesis (P.A.)
21082	palatal augmentation prosthesis (P.A.)
21083	palatal lift prosthesis (P.A.)
21084	speech aid prosthesis (P.A.)
21085	oral surgical splint (P.A.)
21086	auricular prosthesis (P.A.)
21087	nasal prosthesis (P.A.)
21088	facial prosthesis (P.A.) (I.C.)
21089	Unlisted maxillofacial prosthetic procedure (P.A.) (I.C.)
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21116	Injection procedure for temporomandibular joint arthrography
	Repair, Revision, and/or Reconstruction
21137	Reduction forehead; contouring only (P.A.)
21138	contouring and application of prosthetic material or bone graft (includes obtaining autograft) (P.A.)
21139	contouring and setback of anterior frontal sinus wall (P.A.)
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft (P.A.)
21142	two pieces, segment movement in any direction, without bone graft
21143	three or more pieces, segment movement in any direction, without bone graft
21145	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (P.A.)
21146	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft) (P.A.)
21147	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies) (P.A.)
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome) (P.A.)
21151	any direction, requiring bone grafts (includes obtaining autografts) (P.A.)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I (P.A.)
21155	with LeFort I (P.A.)
21159	Reconstruction midface, LeFort III (extra- and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I (P.A.)
21160	with LeFort I (P.A.)
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts) (P.A.)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts) (P.A.)
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial (P.A.)
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm (P.A.)
21183	total area of bone grafting greater than 40 sq cm but less than 80 sq cm (P.A.)
21184	total area of bone grafting greater than 80 sq cm (P.A.)
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts) (P.A.)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft (P.A.)
21194	with bone graft (includes obtaining graft) (P.A.)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation (P.A.)
21196	with internal rigid fixation (P.A.)
21198	Osteotomy, mandible, segmental (P.A.)
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard) (P.A.)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) (P.A.)
21209	reduction (P.A.)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft) (P.A.)
21215	mandible (includes obtaining graft) (P.A.)
21230	Graft; rib cartilage, autogenous, to face, chin, nose, or ear (includes obtaining graft) (P.A.)
21235	ear cartilage, autogenous, to nose or ear (includes obtaining graft) (P.A.)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft) (P.A.)
21242	Arthroplasty, temporomandibular joint, with allograft (P.A.)
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement (P.A.)
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate) (P.A.)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia) (P.A.)
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts) (P.A.)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach (P.A.)
21261	combined intra- and extracranial approach (P.A.)
21263	with forehead advancement (P.A.)
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach (P.A.)
21268	combined intra- and extracranial approach (P.A.)
21270	Malar augmentation, prosthetic material (P.A.)
21275	Secondary revision of orbitocraniofacial reconstruction (P.A.)
21280	Medial canthopexy (separate procedure) (P.A.)
21282	Lateral canthopexy (P.A.)
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach (P.A.)
21296	intraoral approach (P.A.)
	Other Procedures
21299	Unlisted craniofacial and maxillofacial procedure (P.A.) (I.C.)
	Fracture and/or Dislocation
21300	Closed treatment of skull fracture without operation
21310	Closed treatment of nasal bone fracture without manipulation
21315	Closed treatment of nasal bone fracture; without stabilization
21320	with stabilization
21325	Open treatment of nasal fracture; uncomplicated
21330	complicated, with internal and/or external skeletal fixation
21335	with concomitant open treatment of fractured septum
21336	Open treatment of nasal septal fracture, with or without stabilization
21337	Closed treatment of nasal septal fracture, with or without stabilization
21338	Open treatment of nasoethmoid fracture; without external fixation
21339	with external fixation
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire, or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
21343	Open treatment of depressed frontal sinus fracture
21344	Open treatment of complicated (e.g., comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation
21347	requiring multiple open approaches
21348	with bone grafting (includes obtaining graft)
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation
21356	Open treatment of depressed zygomatic arch fracture (e.g., Gilles approach)
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21365	Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches
21366	with bone grafting (includes obtaining graft)
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)
21386	periorbital approach
21387	combined approach
21390	periorbital approach, with alloplastic or other implant
21395	periorbital approach with bone graft (includes obtaining graft)
21400	Closed treatment of fracture of orbit, except blowout; without manipulation
21401	with manipulation
21406	Open treatment of fracture of orbit, except blowout; without implant
21407	with implant
21408	with bone grafting (includes obtaining graft)
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21422	Open treatment of palatal or maxillary fracture (LeFort I type)
21423	complicated (comminuted or involving cranial nerve foramina), multiple approaches
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation
21433	complicated (e.g., comminuted or involving cranial nerve foramina), multiple surgical approaches
21435	complicated, utilizing internal and/or external fixation techniques (e.g., head cap, halo device, and/or intermaxillary fixation)
21436	complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450	Closed treatment of mandibular fracture; without manipulation
21451	with manipulation
21452	Percutaneous treatment of mandibular fracture, with external fixation
21453	Closed treatment of mandibular fracture with interdental fixation
21454	Open treatment of mandibular fracture with external fixation
21461	Open treatment of mandibular fracture; without interdental fixation
21462	with interdental fixation
21465	Open treatment of mandibular condylar fracture
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	Open treatment of temporomandibular dislocation
21495	Open treatment of hyoid fracture
21497	Interdental wiring, for condition other than fracture

Other Procedures

21499	Unlisted musculoskeletal procedure, head (I.C.)

ARTHROSCOPY

29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure) (P.A.)
29804	Arthroscopy, temporomandibular joint, surgical (P.A.)
29999	Unlisted procedure, arthroscopy (I.C.)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	RESPIRATORY SYSTEM
	NOSE
	Excision
30130	Excision turbinate, partial or complete, any method
30140	Submucous resection turbinate, partial or complete, any method
	Repair
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600	oronasal
	Other Procedures
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
30906	subsequent
30999	Unlisted procedure, nose (I.C.)
	ACCESSORY SINUSES
	Incision
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)
31020	Sinusotomy, maxillary (antrotomy); intranasal
31030	radical (Caldwell-Luc) without removal of antrochoanal polyps
31032	radical (Caldwell-Luc) with removal of antrochoanal polyps
	Excision
31225	Maxillectomy; without orbital exenteration

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Endoscopy
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy
31267	with removal of tissue from maxillary sinus
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression
31293	with medial orbital wall and inferior orbital wall decompression
31294	with optic nerve decompression
	Other Procedures
31299	Unlisted procedure, accessory sinuses (I.C.)
	LARYNX
	Introduction
31500	Intubation, endotracheal, emergency procedure
31502	Tracheotomy tube change prior to establishment of fistula tract
	TRACHEA AND BRONCHI
	Incision
31600	Tracheostomy, planned (separate procedure)
31603	Tracheostomy, emergency procedure; transtracheal
31605	cricothyroid membrane
	HEMIC AND LYMPHATIC SYSTEMS
	LYMPH NODES AND LYMPHATIC CHANNELS
	Excision
38500	Biopsy or excision of lymph node(s); open, superficial
38505	by needle, superficial (e.g., cervical, inguinal, axillary)
38510	open, deep cervical node(s)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	DIGESTIVE SYSTEM
	LIPS
	Excision
40490	Biopsy of lip
40500	Vermilionectomy (lip shave), with mucosal advancement
40510	Excision of lip; transverse wedge excision with primary closure
40520	V-excision with primary direct linear closure
40525	full thickness, reconstruction with local flap (e.g., Estlander or fan)
40527	full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530	Resection of lip, more than one-fourth, without reconstruction
	Repair (Cheiloplasty)
40650	Repair lip, full thickness; vermilion only
40652	up to half vertical height
40654	over one-half vertical height, or complex
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701	primary bilateral, one stage procedure
40702	primary bilateral, one of two stages
40720	secondary, by recreation of defect and reclosure
40761	with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
	Other Procedures
40799	Unlisted procedure, lips (I.C.)
	VESTIBULE OF MOUTH
	Incision
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801	complicated
40804	Removal of embedded foreign body, vestibule of mouth; simple
40805	complicated
40806	Incision of labial frenum (frenotomy)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Excision, Destruction
40808	Biopsy, vestibule of mouth
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair
40812	with simple repair
40814	with complex repair
40816	complex, with excision of underlying muscle
40818	Excision of mucosa of vestibule of mouth as donor graft
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (e.g., laser, thermal, cryo, chemical)
	Repair
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less
40831	over 2.5 cm or complex
40840	Vestibuloplasty; anterior (P.A.)
40842	posterior, unilateral (P.A.)
40843	posterior, bilateral (P.A.)
40844	entire arch (P.A.)
40845	complex (including ridge extension, muscle repositioning) (P.A.)
	Other Procedures
40899	Unlisted procedure, vestibule of mouth (I.C.)
	TONGUE AND FLOOR OF MOUTH
	Incision
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	sublingual, superficial
41006	sublingual, deep, supramylohyoid
41007	submental space
41008	submandibular space
41009	masticator space
41010	Incision of ligual frenum (frenotomy)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	submental
41017	submandibular
41018	masticator space
	Excision
41100	Biopsy of tongue; anterior two-thirds
41105	posterior one-third
41108	Biopsy of floor of mouth
41110	Excision of lesion of tongue without closure
41112	Excision of lesion of tongue with closure; anterior two-thirds
41113	posterior one-third
41114	with local tongue flap
41115	Excision of lingual frenum (frenectomy)
41116	Excision, lesion of floor of mouth
41120	Glossectomy; less than one-half tongue
41130	hemiglossectomy
41135	partial, with unilateral radical neck dissection
41140	complete or total, with or without tracheostomy, without radical neck dissection
41145	complete or total, with or without tracheostomy, with unilateral radical neck dissection
41150	composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection
41153	composite procedure with resection floor of mouth, with suprahyoid neck dissection
41155	composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)
	Repair
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue
41251	posterior one-third of tongue
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex
	Other Procedures
41500	Fixation of tongue, mechanical, other than suture (e.g., K-wire)
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)
41520	Frenoplasty (surgical revision of frenum, e.g., with Z-plasty)
41599	Unlisted procedure, tongue, floor of mouth (I.C.)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	DENTOALVEOLAR STRUCTURES
	Incision
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806	bone
	Excision, Destruction
41820	Gingivectomy, excision gingiva, each quadrant (P.A.) (I.C.)
41821	Operculectomy, excision pericoronal tissues
41822	Excision of fibrous tuberosities, dentoalveolar structures
41823	Excision of osseous tuberosities, dentoalveolar structures
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41826	with simple repair
41827	with complex repair
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830	Alveolectomy, including curettage of osteitis or sequestrectomy
41850	Destruction of lesion (except excision), dentoalveolar structures (I.C.)
	Other Procedures
41874	Alveoloplasty, each quadrant (specify)
41899	Unlisted procedure, dentoalveolar structures (I.C.)
	PALATE AND UVULA
	Incision
42000	Drainage of abscess of palate, uvula
	Excision, Destruction
42100	Biopsy of palate, uvula
42104	Excision, lesion of palate, uvula; without closure
42106	with simple primary closure
42107	with local flap closure

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
42120	Resection of palate or extensive resection of lesion
42140	Uvulectomy, excision of uvula (P.A.)
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)
42160	Destruction of lesion, palate or uvula (thermal, cryo, or chemical)
	Repair
42180	Repair, laceration of palate; up to 2 cm
42182	over 2 cm or complex
42200	Palatoplasty for cleft palate, soft and/or hard palate only
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210	with bone graft to alveolar ridge (includes obtaining graft)
42215	Palatoplasty for cleft palate; major revision
42220	secondary lengthening procedure
42225	attachment pharyngeal flap
42226	Lengthening of palate, and pharyngeal flap
42227	Lengthening of palate, with island flap
42235	Repair of anterior palate, including vomer flap
42260	Repair of nasolabial fistula
42280	Maxillary impression for palatal prosthesis (P.A.)
42281	Insertion of pin-retained palatal prosthesis (P.A.)
	Other Procedures
42299	Unlisted procedure, palate, uvula (I.C.)
	SALIVARY GLAND AND DUCTS
	Incision
42300	Drainage of abscess; parotid, simple
42305	parotid, complicated
42310	Drainage of abscess; submaxillary or sublingual, intraoral
42320	submaxillary, external
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral
42335	submandibular (submaxillary), complicated, intraoral
42340	parotid, extraoral or complicated intraoral

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Excision
42400	Biopsy of salivary gland; needle
42405	incisional
42408	Excision of sublingual salivary cyst (ranula)
42409	Marsupialization of sublingual salivary cyst (ranula)
42410	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
42415	lateral lobe, with dissection and preservation of facial nerve
42420	total, with dissection and preservation of facial nerve
42425	total, en bloc removal with sacrifice of facial nerve
42440	Excision of submandibular (submaxillary) gland
42450	Excision of sublingual gland
	Repair
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple
42505	secondary or complicated
42507	Parotid duct diversion, bilateral (Wilke type procedure);
42508	with excision of one submandibular gland
42509	with excision of both submandibular glands
42510	with ligation of both submandibular (Wharton's) ducts
	Other Procedures
42550	Injection procedure for sialography
42600	Closure salivary fistula
42650	Dilation salivary duct
42660	Dilation and catheterization of salivary duct, with or without injection
42665	Ligation salivary duct, intraoral
42699	Unlisted procedure, salivary glands or ducts (I.C.)
	PHARYNX, ADENOIDS, AND TONSILS
	Incision
42700	Incision and drainage abscess; peritonsillar
42720	retropharyngeal or parapharyngeal, intraoral approach
42725	retropharyngeal or parapharyngeal, external approach

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Excision, Destruction
42800	Biopsy; oropharynx
42802	hypopharynx
42804	nasopharynx, visible lesion, simple
42806	nasopharynx, survey for unknown primary lesion
42808	Excision or destruction of lesion of pharynx, any method
42809	Removal of foreign body from pharynx
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues
42815	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844	closure with local flap (e.g., tongue, buccal)
42845	closure with other flap
42860	Excision of tonsil tags
42870	Excision or destruction lingual tonsil, any method (separate procedure)
	Repair
42900	Suture pharynx for wound or injury
	Other Procedures
42960	Control oropharyngeal hemorrhage, primary or secondary (e.g., post-tonsillectomy); simple
42961	complicated, requiring hospitalization
42962	with secondary surgical intervention
42970	Control of nasopharyngeal hemorrhage, primary or secondary (e.g., post-adenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery
42971	complicated, requiring hospitalization
42972	with secondary surgical intervention
42999	Unlisted procedure, pharynx, adenoids, or tonsils (I.C.)

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	NERVOUS SYSTEM
	EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM
	Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic and Therapeutic
	Somatic Nerves
64400	Injection, anesthetic agent; trigeminal nerve, any division or branch
	Destruction by Neurolytic Agent (e.g., Chemical, Thermal, Electrical, Radiofrequency, or Chemodenervation)
	Somatic Nerves
64600	Destruction by neurolytic agent, trigeminal nerve, supraorbital, infraorbital, mental, or inferior alveolar branch
	Neuroplasty (Exploration, Neurolysis or Nerve Decompression)
64722	Decompression, unspecified nerve(s) (specify)
64727	Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty.) (Neuroplasty includes external neurolysis.)
	Transection or Avulsion
64732	Transection or avulsion of; supraorbital nerve
64734	infraorbital nerve
64736	mental nerve
64738	inferior alveolar nerve by osteotomy
64740	lingual nerve
	Neurorrhaphy
64864	Suture of facial nerve; extracranial

624 Service Codes and Descriptions: Surgical Services (cont.)

Service Code	Service Description
	Neurorrhaphy with Nerve Graft
64885	Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length
	Other Procedures
64999	Unlisted procedure, nervous system (I.C.)

OPERATING MICROSCOPE

69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure.)

625 Service Codes and Descriptions: Radiology Services

The following service codes are reimbursable only when performed in an office location.

DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

HEAD AND NECK

70100	Radiologic examination, mandible; partial, less than four views
70110	complete, minimum of four views
70140	Radiologic examination, facial bones; less than three views
70150	complete, minimum of three views
70160	Radiologic examination, nasal bones, complete, minimum of three views
70210	Radiologic examination, sinuses, paranasal, less than three views
70220	Radiologic examination, sinuses, paranasal, complete, minimum of three views
70240	Radiologic examination, sella turcica
70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral
70330	bilateral
70360	Radiologic examination; neck, soft tissue
70380	Radiologic examination, salivary gland for calculus

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Information Required for Admission Screening

The following is a list of information the admitting provider or designee must give the MassHealth Utilization Management contractor when proposing an elective admission. MassHealth may request additional information at any time to clarify the details of any admission. See 130 CMR 450.208 for regulations about admission screening.

- the member's name and address
- the member's sex
- the member's date of birth
- the member's MassHealth identification number
- the guardian's name and address, if applicable
- if applicable, the name of the member's primary care clinician (PCC) and one of the following:*
  - the telephone number of the PCC
  - the provider number of the PCC
  - the address of the PCC
- if applicable, whether the PCC has been notified of the proposed admission
- other health-insurance information
- whether the member is being treated as a result of an accident, and if available, the date and type of accident
- the expected or actual dates of admission and expected discharge date
- the name and provider number of the attending physician
- the name of the hospital
- the primary and secondary diagnoses
- the primary and secondary procedures, if applicable
- the ICD-9-CM codes for both the diagnoses and procedures, if available
- CPT codes for procedures when the facility is out of state
- clinical information that supports the medical necessity of the proposed admission and/or procedure
- other pertinent information the admitting provider has considered in deciding to admit the member

***** Information about the member's PCC is not required if the admission is for dental, oral-surgery, family-planning, or abortion services.

Please Note: Admission screening does not satisfy the need to obtain prior authorization (PA) for services that require PA. See 130 CMR 450.303, 420.000, and Subchapter 6 of the *Dental Manual* to determine what services require PA. See Subchapter 5 of the *Dental Manual* for instructions for requesting PA.

Contact for Utilization Management Program

Contact information for the MassHealth Utilization Management Program contractor is given below. (See 130 CMR 450.207 through 450.209 for the Utilization Management Program regulations.)

MassPRO, Inc.
235 Wyman Street
Waltham, MA 02451-1231

Fax: 1-800-752-6334
Telephone: 1-800-732-7337

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